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ORIGINAL PAPERS

ON THE PSYCHO-ANALYTIC THEORY OF THINKING[1]

By DAVID RAPAPORT, PH.D., STOCKBRIDGE, MASS.

I

The aim of this paper is to piece together what the science of psycho-analysis has taught us concerning thinking.

Such an attempt is fraught with inevitable difficulties. First, it is of necessity incomplete: there is more to cover than time allows. Second, psycho-analytic writing on thinking is fragmentary and belongs to various stages of the development of psycho-analysis; consequently, it requires interpretation and speculative completion. Presenting it therefore invites the time-worn critique: what is good in it is not new and what is new is not good. Third: the psycho-analytic theory of thinking is a part of meta-psychology—which, dealing as it does with abstractions and being several steps removed from immediate therapeutic concern, remains the least familiar and to many the least palatable part of psycho-analytic theory. Fourth: the psychology of thinking is in the main ego psychology; and since psycho-analytic ego psychology itself is still in the early phases of its evolution, it does not offer a solid framework for the psychology of thinking. In fact, some of the future development of other aspects of ego psychology will depend on developments in the psychology of thinking. Fifth: the psycho-analytic psychology of thinking cannot be a bridge between psycho-analysis and a solidly built academic theory of thinking because the latter likewise is still fragmentary. Yet the psycho-analytic theory of thinking cannot disregard the important beginnings that have been made in academic psychology.

In so far as my attempt fails, I believe it is that the task exceeds my ability. The necessity and feasibility of the task should not be doubted: we need a crystallization of the psycho-analytic theory of thinking from its fragments; this theory must be cast as an indispensable part of psycho-analytic ego psychology; it can be formulated only in metapsychological terms considering the genetic, structural, dynamic and economic points of view. And last, but not least, it must extend into the field of the academic theory of thinking to congelate the beginnings of the dynamic understanding of thinking to be found there.

II

For the psycho-analyst it must be clear that the point of departure in understanding thinking is that the thought process is motivated by the instinctual drives. It will be remembered that Freud maintained that all thinking is a détour from the direct path towards gratification (1). Since Freud used the word ' ideation ' for the product of the primary thought process and ' thinking ' for those of the secondary process (2), it is clear that he regards the détour as motivated by instinctual drives as much as is the direct path, the secondary process as much as is the primary (3). To understand Freud's view of the secondary process, we shall have to review first the dynamics of the primary process.

We will first give Freud's view of the state of affairs as it is assumed to exist prior to the development of ideation and the primary process. The construction is, of course, only a

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schema. When the potential energy of an instinctual drive rises to a certain critical point—and the object of the drive is present—the sluices of motility open and the discharge of tension takes place (4). This can be stated in other words by saying that when a tension, usually referred to as a ' need ', reaches a certain intensity and the need-satisfying object is present, discharge of tension takes place. From the point of view of the dynamics of instinctual drives this process is called gratification (5). From the point of view of the regulation of psychic energy distribution the process is subsumed under the concept of the pleasure principle (6). From the point of view of energy dynamics in general the process reveals the fundamental tendency of all energy, namely that towards even distribution. From what Freud would have called the biological point of view, this process is the direct discharge or gratification discharge of cathexes, requiring as a condition of discharge and deriving its biological usefulness from the presence of the need-satisfying object (7). As we shall see later, the secondary process requires the fulfilment of considerably more complex conditions before discharge can take place, and its biological usefulness is characterized by experimental action with small quantities of energy. The distinction between the two is epitomized by Freud in the contrasting concepts of gratification discharge and action (8).

So far we have described the concepts related to the process of the primordial gratification discharge. Freud's concept is that ideation arises only when this process is interfered with. When the need tension rises to the point where discharge should take place but the need-satisfying object is not present, the discharge is delayed. During this externally-imposed delay begin the changes which are to have such far-reaching significance for the development of the psychic apparatus. Here is the beginning of the détour on the road towards gratification (9).

There are two main effects of this delay. One can be observed; the other must be reconstructed. The observed effect is generalized undifferentiated restlessness which Freud views as the discharge of the drive tension into the soma, this discharge substituting for the direct gratification discharge. This discharge into the soma Freud conceptualizes as affect discharge and considers it the archetype of all affective behaviour. A later formulation of affect discharge contrasts it with motor action. The latter is an attempt to change the external environment, to re-establish safe conditions of gratification; while the affect discharge is directed at changing the internal somatic rather than the external environment (10).

The second effect of the delay of discharge, an effect which is a construction rather than an observation, is the emergence of an hallucinatory image of the need-satisfying object when tension rises to the point where discharge should take place but the need-satisfying object is not present. The hallucinatory image is the archetype of thought. Its appearance in consciousness is determined by the drive tension; it is the fundamental element in the primary process; it represents that special case of the pleasure principle which is conceptualized as wish-fulfilment (11). In the absence of the need-satisfying object the alternative of the hallucinatory revival of the original gratification is chosen. Concerning the rôle of this hallucinatory image in the primary process and the other characteristics of the primary process we will say more later.

The biological utility of this hallucinatory image is difficult to discern. It is an abortive effort at discharge. It provides neither the gratification of direct discharge nor the advantages of experimenting with small quantities of energy. From the economic point of view—or to put it otherwise, the point of view of cathectic dynamics—the emergence of the hallucinatory image of the need-satisfying object is possible only because of the mobile character of the drive energies or cathexes. It is because the cathexes are mobile that they can be displaced from the perception of the need-satisfying object to the memory trace of this object, thus imparting to the memory trace an intensity which makes it hallucinatorily vivid (12).

From the point of view of the instinctual drive the hallucinatory image is an instinct representation since its emergence in consciousness indicates that the need tension arising from the instinctual drive has mounted to the point at which it is seeking discharge. From the point of view of memory theory the appearance of the memory of a need-satisfying object in the hallucinatory form in consciousness indicates that the memory is cathected by, that is to say, charged with the energy of the instinctual drive (13). Clearly instinct representation and cathected memory trace are two different conceptualizations of a state of a memory or idea. The study of the hallucinations of psychotics, the descrip-

tions of illusions of people on the brink of starvation or dehydration, and the analysis of hypnagogic and dream hallucinations are the empirical data from which these retrospective reconstructions have been derived. Out of these, and particularly out of the study of hallucinatory deliria (Meynert's amentia), we may derive empirical evidence to show that the hallucinatory image does not provide by its momentary appearance more than a minute opportunity for discharge. If the hallucinatory attempt at gratification becomes continuous, as in hallucinatory deliria, death results by exhaustion (14). The transition from these highly cathected hallucinatory images to memory traces cathected by minute amounts of energy is the transition from the primary to the secondary process. The conditions of this transition will be discussed in further detail below.

From the genetic point of view a more complete description of the hallucinatory image must be made, and from it important conclusions may be derived concerning the primary process. From developmental psychology we know that the original experience of the need-satisfying object is a diffuse undifferentiated experience in which visual, acoustic, tactile, thermal, cutaneous, kinæsthetic, and other stimulations are fused. Discrete objects do not as yet exist, and thus the need-satisfying object itself is not differentiated from the context in which it appears nor even from the experiences immediately preceding or following it (15).

It is this diffuse global image of the need-satisfying object which is pushed into consciousness when instinctual tension mounts. In the course of development this diffuse image differentiates into discrete objects and experiences, all of which are still related to instinctual drives in the same fashion as was the original undifferentiated image of the need-satisfying object. Thus we find a multitude of instinct representations replacing the original undifferentiated instinct representation, any of which are mutually interchangeable since their essential meaning is that they are representations of the instinctual drive. From the point of view of the theory of thinking and the theory of memory we have here what may be called a drive organization of memories. Empirically we observe such organization even after the establishment of the secondary process. For instance, when we trace the unconscious sources of slips-of-the-tongue (as Freud did in his *Psychopathology of Everyday Life*) we find that the free associations to the slip map out for us single examples of such drive-organized memory systems. Similar observations can be made in selective amnesias or in fugues (16).

Within such systems of drive-organizations of memories the mobile drive cathexes can be freely displaced. The equivalence of all memories within such a system makes possible the condensation of any number of such instinct representations into a composite one of heightened energic cathexis, since the composite combines the cathexes of the separate representations. Such condensations are familiar to all of us from the study of dreams.

We see that this description of the evolution of the hallucinatory image makes plausible the nature and origins of the mechanisms of the primary process (17).

From the topographic point of view we must note that the hallucinatory image is the archetype of consciousness and that intense drive cathexes may, under certain conditions, be alone responsible for making an idea conscious. Later on we shall see that the most common form of consciousness, as encountered in secondary process thinking, is from the point of view of cathectic dynamics quite different (18). Yet we are already warned here that consciousness is not a single genotype but rather a phenotype which may have various genetic and causal roots. Consciousness during dreaming for instance—like that of the hallucinatory image—is one in which the intensely concentrated drive cathexes make for consciousness. The necessary concentration of cathexes is obtained by the primary process mechanisms of condensation and displacement. Dream consciousness also seems feasible in the main only in conjunction with visual images serving as instinct representations. The state of consciousness referred to as dream consciousness is thus in the main motivated by drive cathexes and carries in the main the character of visual imagery as its major formal characteristic. The latter Freud expressed in the theory of dreams by the concept of ' regard for representability ' (19).

III

So far we have sketched the psycho-analytic conception of the primary process. We found it working with mobile cathexes, regulated by the pleasure principle, striving towards direct gratification discharge. We have seen the emergence during the period of delay of discharge of hallucinatory images of need-satisfying objects. Pursuing the fate of these images into

the early course of development, we have seen how two of the mechanisms of the primary process, condensation and displacement, follow, as it were, of necessity (20). Our next task is to reconstruct the conditions under which the secondary process arises.

From the structural point of view, the emergence of the secondary process is one aspect of early ego development in its differentiation from the id (21). In psycho-analytic writing the discussion of early ego development is most frequently dealt with in terms of introjection and identifications. These aspects of ego development, though certainly of fundamental significance for the theory of both normal and pathological thinking, we shall have to bypass here (22). The aspects of early ego development with which we shall deal are rather those of the first structuralization of the control of impulse—the prototype of defence—and the development of reality testing (23).

The primary process aimed at direct discharge of cathexes, and when circumstances delayed such discharge substituted for it wish-fulfilment in the form of hallucinatory revival of the need-satisfying object. The secondary process converts this involuntary delay due to external circumstances into an internally controlled delay (24), assuring postponement of discharge until external reality conditions have been found suitable for discharge. We know that this détour as often as not implies not only search for suitable conditions in reality but also motor action designed to change reality so as to make it more suitable (25). The core of this change from the primary to the secondary process appears to be the change in the character of delay. The delay to begin with was due to external circumstances and is turned into an ability to delay, into an internal control. Thus is a necessity made a virtue.

From the point of view of cathectic dynamics, some aspects of this change in the character of delay are familiar to us from the theory of repression. While repression proper—or as it is sometimes called, ' after expulsion '—can be conceived of dynamically in terms of the withdrawal of conscious and preconscious cathexes, the study of the conditions of primal repression necessitates the assumption of counter-cathexes which expresses the dynamic implication of the change in the character of delay (26). With the introduction of the concept of counter-cathexes, psycho-analytic theory introduced the fundamental concept of impulse controls, which is central to our conception of the structure of the ego. Little is known about the nature of the process by which these counter-cathexes arise. It is possible that their precursors are to be found in what Freud referred to as ' the stimulus barrier ' (27) or in what Hartmann referred to as ' maturation of organic control structures ' (28). Be that as it may, we are not lacking analogies in energy organization processes that can make the emergence of such control organizations as counter-cathexes plausible (29). It is a rather common occurrence for energy distributions which usually strive for discharge, when they are prevented from doing so, to structuralize to prevent or regulate their own discharge.

From the structural point of view these counter-cathexes set the fundamental pattern for ego controls, and their emergence is thus one of the crucial steps in ego development. Though Freud's conception of them seems to be closely tied up with the theory of repression, it will be well to remember that their significance is far broader than would be implied by the current use of the concept repression. The earlier concept of repression as Freud used it in the period between 1910 and 1915 was a global one, including all defensive processes of the ego. It seems probable that all defences are varieties of counter-cathectic organizations (30). It therefore becomes clear that the controlled delay described above is the prototype of defence. It will also be worthy of note that in these counter-cathexes we see the prototype of the energies that become bound in the structuralizing process of ego-development and thus become the energies at the disposal of the ego (31).

While this process of structuralizing is progressing the primary drive organization of memories also undergoes significant alterations. The establishment of delays and controls results in the development of partial drives (32). The progressive differentiation of the objects of these partial drives, coupled with the enrichment by experience of the range of instinct representations organized in closed systems of drive representations, results in overlapping systems in which, depending on its context, an idea or object may be a representation of any of several drives. Thus the exclusive equivalence of ideas in terms of the drive around which they are organized breaks down and transitions and equivalences between the several systems of drive organizations of memory become feasible. A particular idea is no longer dependent upon

the mounting tension of a single drive for its emergence in consciousness. The cathexis of a particular idea is no longer exclusively referable to a single drive. This change paves the way for the new organization of memories replacing the drive organization of memories. In this new organization, known to us from the experimental investigations of Bartlett and others, conceptual, temporal and spatial belongingness organize ideas into memory frames-of-reference. These conceptual, spatial and temporal frames of reference develop in the course of experience and thus correspond to the relationship patterns of reality (33).

The setting for the secondary process is thus prepared in the counter-cathexes at the disposal of the ego and in the new memory frames of reference replacing drive organizations of memories (34). Besides the results of motor behaviour which differentiate what is external from what is internal (35), it is in these new memory frames of reference that we find the first safeguards for reality testing (36). Yet we must consider this transition process from at least one more vantage point to obtain a clearer picture of the operation of the reality principle and of the process of reality testing.

IV

Freud assumes that in the primitive undifferentiated phase of development in which no differentiated objects as yet exist, there are two qualities in terms of which internal tension becomes conscious. These are pain and pleasure, the former related to mounting tension, the latter to discharge (37). The hallucinatory images of the need-satisfying objects introduce additional new conscious qualities (38). The primitive ideation is still regulated, however, by the pleasure-pain signals arising from the tension inside the psychic apparatus. In the secondary process the organism achieves, by means of the new conscious qualities, a relative liberation from the exclusive rule of these pleasure-pain signals. These new conscious qualities ultimately make up what we refer to as ' thoughts '. Their prototype is the hallucinatory image, itself genetically derived from perception. How is this relative liberation from pleasure-pain signals achieved?

We have already seen that the instinct representation has two aspects—a quantitative and a qualitative one (39). The quantitative one is the affect charge that discharges into the interior of the somatic apparatus, resulting in affect expression or somatic changes of affective origin; the qualitative one is the idea, the cathected memory trace. Both of these serve both as indicators of and safety-valves for mounting drive tension. The quantitative aspect serves especially the safety-valve function and the qualitative serves especially the function of indicator. But both partake of both rôles. Freud was forced to distinguish between these two aspects of instinct representation by observations of hysterical and obsessional conditions. In hysteria the quantitative (affective) aspect of instinct representation is emphasized, while in obsessional conditions it is the qualitative (ideational) aspect which is prominent (40).

Genetically it is clear that this differentiation into two aspects does not begin before the controlling counter-cathectic energy distributions and their structuralization develop. In hallucinatory ideation the two aspects are still indivisible. The differentiation of these two aspects of instinct representation is the prototype of the defence mechanisms of isolation and intellectualization (41). The controlling counter-cathectic energy distributions, once arisen, differentiate affective and ideational instinct representations and thus liberate the new conscious qualities of ideation from the rule of affective pleasure-pain regulation. In this way the new organization of ideas in terms of memory frames of reference can give orientation to reality relationships relatively unencroached upon by intrapsychic pleasure-pain regulations. Thus emerges the reality principle, and thus reality testing by means of memory traces cathected by minute amounts of energy—that is to say, experimental action with minute cathexes (42)—becomes possible.

V

The emergence of counter-cathectic energy distributions, their structuralization, the new organization of memory frames of reference and the reality principle set the stage for the secondary process. A further understanding of the operation of the secondary process may be derived by following the topographic conditions and the corresponding cathectic dynamics that arise with the emergence of these ego organizations and structures.

The little that is known of the cathectic dynamics of the secondary process derives from our understanding of ' after-expulsion '—that is to say of repression proper (43). It is conceived that repression proper begins with the

withdrawal of the cathexes of the conscious and preconscious systems from the ideas to be repressed (44). This is then followed by counter-cathexis of these ideas in order to prevent their continuous re-emergence and the continuous struggle and anxiety which would otherwise ensue (45). These cathexes of the preconscious and conscious are referred to either as ' attention ' cathexes or hyper-cathexes (46). In another context we are familiar with them as delibidinized or sublimated energies (47). In general it may be formulated that these are energies divested of the hallmarks of their instinctual origin even though their instinctual origin as such is not called in question. We have seen how counter-cathexes arose with the beginnings of the emergence of ego structure in the form of controls of drives. It may be conjectured that with the further development of ego structuring, these counter-cathectic energies become available to the ego for uses other than those of counter-cathexis (48). Another way in which we can form a conception of the nature of these conscious cathexes of the ego is the following: the energy distribution of instinctual drives regulated by the pleasure principle is overlaid in the course of development by a superimposed counter-cathectic energy distribution. These two energy distributions together establish a new field of forces. The ego cathexes may be conceived of as those energy exchanges that take place within this new field of forces (49).

It is conceived that only a determinate—that is to say, a limited—amount of such energy is available to the ego. Therefore, once this energy is employed in hypercathexis to make conscious an idea or a group of ideas, it must of necessity be withdrawn from other ideas. Thereby these other ideas, though capable of becoming conscious, remain non-conscious or, as we are accustomed to say, preconscious. This function of conscious cathexes is the dynamic process of attention (50).

This does not, however, tell the whole story of consciousness and attention. First of all we pointed out that intense drive cathexes of ideas—as in hallucinations—may in themselves make an idea conscious, though this is a different kind of consciousness from the usual one. Second, when the drive cathexis of an idea mounts and the drive and its ideational representation are not counter-cathected, the increasing drive cathexis will attract attention to cathexes of consciousness (51). Third, Freud postulated that these hypercathexes link the instinct representations or instinct derivatives with verbal images and thus achieve their becoming conscious (52). Fourth, it became necessary to assume a censorship—that is to say a controlling energy distribution—not only at the point of transition between unconscious and preconscious where the counter-cathexes discussed above are distributed, but also at the point of transition between preconscious and conscious (53). The need for this assumption derives from observations of daydreams and phantasies which have a different form of existence in the preconscious from those ideas which, though fully capable of becoming conscious, are not at a given moment cathected by attention (54). Therefore, fifth, for an idea to become conscious it must pass the censorship between preconscious and conscious —expressed otherwise, there must be no counter-cathectic energy distributions against it as it passes from preconscious to conscious.

VI

Here we arrive at the uncharted, hardly touched areas of the psycho-analytic theory of thinking. Thus what follows can be only recounting of problems and conjectures and nothing more.

We have already seen that the nature of ' consciousness ' of hallucinatory images is dynamically radically different from the usual consciousness of ideas. We have no reason to assume theoretically that these are the only two kinds of consciousness possible. Observation and experience, on the other hand, suggest that there is a group of such states of consciousness ranging between the hallucinatory consciousness characteristic of the dream and waking consciousness. Examples of such states of consciousness and the workers whose names are most closely identified with their study are the following: hypnagogic states, Silberer; Korsakoff patients, Hartmann; paretics, Schilder; amentia, Meynert, Schilder and Hartmann; fugues and amnesias, Janet (55). In the recent exploratory study with more or less continuous recording of the dreams, reveries and thought productions through the nights of several weeks, I believe I have observed a more or less continuous series of such states of consciousness which seemed to me distinguishable from each other by the formal characteristics of their mode of thinking (56). The differences in cathectic dynamics between these states of consciousness and the forms of the thought processes deter-

mined by them are so far unknown. A field of exploration lies wide open here, and a huge gap in our theory of thinking awaits bridging. For the present, cathectic dynamics and thought processes can be dealt with by us only by means of the dichotomy between primary process and secondary process. It is not impossible that a study of the phenomena of this gap referred to will break down this dichotomy and replace it by gradual transitions (57).

For the present, psycho-analytic theory is forced to assume two kinds of censorship, one between unconscious and preconscious and one between preconscious and conscious. In 1927 Jones expressed the idea that it is probable that censorship is distributed in a more diversified—or, as he put it, ' streamlined ' fashion—throughout the psychic apparatus (58). Theoretically we have no good reason to assume that the same process by which the original counter-cathectic energy distribution arose is not repeated over and over again in the course of development of the ego structure. Every counter-cathecting energy distribution can give rise to a new energy distribution, the delays of discharges within which structuralize to give rise to a new counter-cathecting energy distribution and so forth *ad infinitum*. In fact, the observations of conscious thought processes may give some support to such an assumption. In the acquisition of a new set of abstract concepts, there is a struggle characterized by occasional falling back upon the concrete data from which the abstractions were derived. When the acquisition is complete there is an energy-saving and ease of operation which make the new set of concepts well conceived of as a hypercathectic organization. It seems clear that there is an intrinsic relationship between this set of problems related to censorship, counter-cathectic and hypercathectic energy distributions on the one hand, and the above-discussed problems of variants of thought processes in different states of consciousness on the other.

Another intriguing problem of the secondary process is that of the character of ego cathexes. Are these all independent and undirected energies that the ego can manipulate freely, or are they directed energies whose use remains more or less determined by their instinctual origin ? (59). An approach to this problem must remain mindful of the great influence that attitudes, conscious strivings, opinions, biases, and so forth can exert on an individual's thought organization (60). There is even experimental evidence to show that conscious strivings may give rise to thought formations showing some resemblance to those produced by primary processes. Mueller, Ach and others have observed such thought formations and labelled them ' apperceptive fusions ' (61). The theoretical question such observations pose is this: Is it necessary to assume every time such an attitude or striving organizes conscious thought in a fashion not consistent with the laws of the secondary process that instinctual drives have asserted themselves, as they do, for instance, in slips-of-the-tongue? Two alternate hypotheses to this assumption are possible: first, it could be assumed, as Kris has demonstrated for poetic creation and the comic, that in these thought organizations the ego makes use of the primary process for its purposes (62), or second, it could be assumed that every counter-cathectic organization of energies gives rise to a new set of forces which, though derivatives of the original instinctual drives, have a degree of independence from them. At this stage of the game no decision among these three hypotheses is possible. It is, however, probable that the last hypothesis, since it implies relatively independent ego forces, will prove more consistent with our present theory formation, dominated as it is by our interest in exploring the extent of the independence of the ego as a dynamic structure (63).

To summarize: *Genetically* the thought process is conceived of as arising in the form of hallucinatory images and ideas of drive objects, or hallucinatory wish-fulfilments, and to develop into a process of détour on the way toward gratification. Genetically, therefore, we distinguish primary and secondary processes. The former strive for full immediate discharge of tensions, operate with mobile cathexes, and stand under the regulation of the pleasure principle. On the basis of the equivalence of all ideas which are representations of the same drive the primary process employs condensation, displacement and other mechanisms, in pursuing its aims of tension discharge. The secondary process operates with small amounts of bound cathexes, and allows no discharge before experimental action with these small amounts has proved that the action is likely to decrease tension; it assumes equivalences not in terms of representations of the same drive, but in terms of reality relations and meaning, being regulated by the reality principle.

Topographically thought processes may be either unconscious (primary processes), or

preconscious and conscious (secondary processes). This parallelism of conscious and primary, on the one hand, and preconscious-conscious and secondary on the other, is somewhat arbitrary, since the ego may use primary processes too for its purposes as in wit, inspiration, etc., by hypercathecting them (see Kris). There are, however, at this point problems of cathectic dynamics which await future clarification. The criteria for distinguishing these so-called topographical concepts are achieved in psycho-analytic metapsychology more or less exclusively in terms of differential characteristics of cathectic processes.

Structurally the emergence and development of thought processes is one aspect of the emergence and development of the ego, and thought processes are integral parts of ego-processes. They are an outstanding aspect and instrument of reality testing subserving the reality principle. The interesting and important problems of the rôle of thought processes in the synthetic and differentiation processes of the ego have not been discussed. Nor have we touched on the relationship of thought processes to skills, motor abilities, etc., i.e. to the whole field of problems Hartmann referred to as the conflict-free ego sphere.

Economically we have traced the development of cathectic (energy) distributions. We have followed the development from mobile to bound cathexes and clarified the concepts of countercathexes, hypercathexes, attention cathexes, and delibidinized or sublimated energies. We have attempted to show how the development of systems of control of cathexes by systems of energies of a higher cathectic level though of lesser intensity comes about. We have dwelt on the functions of consciousness and attention and defined both in terms of cathectic dynamics.

Finally, we have shown that *from the biological point of view* thinking is experimental action with small amounts of energy. Thinking explores the possible pathways of action to find the one of least resistance, least danger, and greatest directness, while preserving almost intact the energy necessary for motor action. This formulation integrates the biological advantage of thinking into the psycho-analytic theory of thinking.

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Compare also BERGMAN, P., and ESCALONA, S. 'Unusual Sensitivities in Very Young Children', *The Psychoanalytic Study of the Child,* Vol. III/IV. (Internat. Universities Press, 1949.)

(28) HARTMANN, H. 'Ego Psychology and the Problem of Adaptation', *Int. Z. f. Psychoanal. und Imago,* **24,** 62–133, 1939.

(29) FREUD, S. 'The Interpretation of Dreams', p. 537. (See (1).)

(30) See particularly Freud's 'The Unconscious', p. 119 (see (10)) concerning 'negation' and compare with Freud's 'Negation', *Int. J. Psycho-Anal.,* **6,** 367–371, 1925. A general comparison of the papers, Freud's 'Unconscious' and 'Repression' (see (13)) on the one hand, and Freud's *The Problem of Anxiety* (New York: Norton, 1936) and A. Freud's *The Ego and the Mechanisms of Defense* (New York: Internat. Univ. Press, 1946) on the other, illustrates this point.

See also FENICHEL, O., *The Psychoanalytic Theory of Neurosis.* (See (23).)

(31) FREUD S. *The Ego and the Id,* pp. 64–65. (See (21).)

—— *Beyond the Pleasure Principle,* pp. 34–36. (See (27.))

(32) —— 'Three Contributions to the Theory of Sex', pp. 593 *ff.* 597 *ff.* 614 *ff.* In *The Basic Writings of Sigmund Freud,* ed Brill. (New York: Modern Library, 1938.)

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(33) —— 'Formulations Regarding the Two Principles in Mental Functioning', p. 16. (See (2).)

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(34) Compare RAPAPORT. 'Psychological Testing, its Practical and its Heuristic Significance' pp. 245–262, *Samiksa,* Journal of the Indian Psychoanalytical Society, **1,** 245–262, 1947.

(35) FREUD, S. 'Metapsychological Supplement to the Theory of Dreams', pp. 148–149. In *Collected Papers,* Vol. IV. (London: Hogarth Press, 1925.)

(36) —— 'The Interpretation of Dreams', pp. 488–492, particularly p. 490. (See (1).)

(37) —— 'The Interpretation of Dreams', p. 545 and p. 546. (See (1).)

—— *Beyond the Pleasure Principle,* p. 2. (See (6).)

(38) —— 'Formulations Regarding the Two Principles in Mental Functioning', p. 15. (See (2).)

—— 'The Interpretation of Dreams', p. 529 and p. 546. (See (1).)

(39) —— 'Repression', p. 91. (See (13).)

—— 'The Unconscious', p. 111. (See (10). Compare also: BRIERLEY, M. 'Affects in Theory and Practice', *Int. J. Psycho-Anal.,* **18,** 256–268, 1937; and GLOVER, E. 'The Psycho-Analysis of Affects', *Int. J. Psycho-Anal.,* **20,** 299–307, 1939.

(40) —— 'Repression', pp. 93 *ff.* (See (13).)

(41) —— *The Problem of Anxiety,* pp. 55–57. (See (30).)

—— 'The Unconscious', pp. 133–136. (See (10).) Yet it is conceivable that a constitutional potentiality, determining what should prevail after the differentiation had taken place, is present from the beginning.

(42) —— 'The Interpretation of Dreams', pp. 533–534. (See (1).)

(43) —— 'Repression', pp. 86–87. (See (13).)

(44) —— ' The Unconscious ', pp. 112–113. (See (10).)

(45) —— ' Repression ', pp. 89–90. (See (13).)

—— ' The Unconscious ', pp. 113–114. (See (10).)

(46) —— ' The Unconscious ', pp. 124–127; pp. 133–134. (See (10).)

—— ' Metapsychological Supplement to the Theory of Dreams ', pp. 148–150. (See (35).)

—— ' The Interpretation of Dreams ', p. 529 and p. 546. (See (1).)

(47) —— *The Ego and the Id*, pp. 62–65. (See (21).)

Compare also RAPAPORT, GILL and SCHAFER. *Diagnostic Psychological Testing*, Vol. I, pp. 166–179 and pp. 195–200. (Chicago: Yearbook Publishers, 1945.)

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(48) FREUD, S. ' The Unconscious ', pp. 113–114. (See (10).)

(49) Compare, however, Hartmann's ' The Theory of the Aggressive Drive '. HARTMANN, KRIS and LOWENSTEIN. ' Notes on the Theory of Aggression ', *The Psychoanalytic Study of the Child*, Vol. III/IV (New York, 1949).

(50) FREUD, S. ' The Interpretation of Dreams ', p. 529. (See (1).)

(51) —— ' The Interpretation of Dreams ', p. 529. (See (1).)

(52) —— *The Ego and the Id*, pp. 21 *ff.* (See (21).)

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—— ' The Unconscious ', pp. 133 *ff.* (See (10). Compare, however, FREUD. *An Outline of Psycho-Analysis*, pp. 41–46.)

(53) —— ' The Unconscious ', pp. 123–127. (See (10).)

(54) Compare KRIS, E. ' On Preconscious Mental Processes '. (Unpublished paper delivered at the 1949 Montreal Meeting of the Amer. Psa. Assn.)

(55) See RAPAPORT. *Emotions and Memory* (See (16)) and RAPAPORT. *Organization and Pathology of Thought*. (Columbia University Press (in press).)

(56) Unpublished exploratory study, some aspects of which are referred to in RAPAPORT, *Organization and Pathology of Thought Processes*. (See (55).)

(57) Compare HARTMANN, H. ' Ego-Psychology '. (Unpublished paper delivered at the 1949 Montreal Meeting of the Amer. Psa. Assn.)

(58) JONES, E. *Papers on Psychoanalysis*. (Baltimore: Williams & Wilkins, 1948.)

(59) Compare HARTMANN, H. (see (49)) and HARTMANN (see (28).)

(60) Compare MURPHY, G. *Personality*, pp. 362 *ff.* (New York: Harper & Bros., 1947.)

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(61) See RAPAPORT. (See (55).)

(62) KRIS, E. ' Approaches to Art ', pp. 354–369. In *Psychoanalysis Today*. (New York: Internat. University Press, 1944.)

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(63) Compare ALLPORT, G. *Personality*, on ' functional autonomy ', pp. 191–211. (New York: Henry Holt, 1937.)

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LANGUAGE AND DREAMS

By SIDNEY J. BAKER, Sydney

When the white man first established himself in the islands of New Zealand in the South Pacific more than a century ago he took with him the domesticated European cat. Before his advent the native Maoris had had no acquaintance with the cat. They therefore had to find a name for it. The name they chose was *tori* or *tore*. Now, this word was already in the Maori language. *Tore* was a term applied to the female genital, and was closely associated with other words which had strongly-sexualized tones, among them *tora*, an erection of the penis, *kiritore*, the labia minora, and *kotore*, the anus.

The question which immediately concerns us is how it came about that the Maoris should choose such a sexually-oriented word as *tore* to apply to the domestic cat. Of course, we have no cut and dried answer. But it will be immediately evident that the association which the Maoris apparently saw between the female genital and the cat is also an association that has cropped up in other lands. In English cant of the seventeenth century *puss* was a term applied to the female genital; later, *puss* became a term of affection for a girl. In England also the term *cat* has been commonly applied both to the female genital and to a harlot. In Australian slang, *pussy* is not infrequently used to denote the female genital, especially the female pubic hair,

Perhaps all these examples might be classed as having the nature of linguistic coincidences were it not for the psycho-analytic discovery that a similar cat–female genital motif occurs in dream symbolism.

Another illustration of the same process is found in the name which the Maoris gave to the gun—also introduced to New Zealand by Europeans. The name was *putara*, which is compounded of two other words: *pu*, meaning a wind instrument, and *tara*, meaning penis. *Pu* has many anal associations in Polynesian dialects. In Samoan it is applied directly to the anus. In Maori, the word *pupa* means to break wind; so does the Samoan *taepu*. The Hawaiian *hopupu* means puffed up with wind, as the bowels. So the idea behind the Maoris' use of *putara* for gun would seem to be that of a penis which makes a noise like an escape of anal flatus. This example is clearly of interest in view of the fact that psycho-analysis has discovered a parallel gun-phallus motif in dream symbolism.

Psycho-analysis also declares that the human unconscious recognises a symbolic identity between the movements of the piston of an internal combustion engine and the act of coitus. We cannot be altogether surprised, therefore, that Maori to-day uses the word *kotiritiri* to describe the movements of a piston and that this word was used earlier to denote coitus.

In the course of expounding his theories of dream interpretation, Freud had a good deal to say about language. He wrote, for example: (1) ' What is to-day symbolically connected was probably united in primitive times by conceptual and linguistic identity.' Elsewhere he said that symbolism was ' not a dream problem, but a problem connected with our archaic thinking, our " primal speech ", as it was aptly called by the paranoic Schreber ' (2). How did Freud arrive at these views? They stemmed directly from his discovery that linguistic problems were continually arising in dreams. For instance, he said: (1) ' One scarcely finds a dream without a double meaning or a play upon words.' Many examples of this double-play are noted in his writings; some particularly interesting examples are grouped in the tenth lecture of his *A General Introduction to Psycho-Analysis* (3).

There is a question, of course, whether this linguistic evidence is adequate in itself; whether, indeed, it does not place some strain on the credulity of persons who have little acquaintance with the intricacies of psycho-analysis. To psycho-analysts it is acceptable because personal experience has shown the validity of Freud's interpretations. But there is always the issue of attempting to make unconscious symbolism understandable to a wider public. Freud certainly recognized this. He also obviously regretted that he was not better equipped

linguistically to illustrate his examples more freely from speech. He declared: (4) ' We cannot dismiss the conjecture which forces itself on us psychiatrists that we should understand the language of dreams better and translate it more easily if we knew more about the development of language.'

Clearly, some useful service might be performed to the cause of psycho-analysis if it were possible to tap the stream of language and draw off the relevant evidence which Freud believed was there. One of the great drawbacks of dream interpretation is that a dream is a highly individual phenomenon. It must be translated into words before it can be interpreted by the analyst and, in the process of that translation, many of the sharp edges which the dream had originally are lost. This is not of grave importance to the psycho-analyst, who is prepared to accept any dream fragment as material on which to work. But it leaves the unbeliever at a disadvantage. A dream cannot be laid out for popular inspection. It is an unstable, individual product which tends to escape our grasp. Language, especially written language, has a singular advantage over dreams. It can be inspected by all. There are few hints of conjuring tricks or black magic about it. Of course, language is by no means entirely stable; it is always being modified, subject to fashion and caprice, but these changes are usually sufficiently slow to allow us to catch its nuances with a minimum of difficulty if our range is wide enough and if our attention is sufficiently alert.

Freud suspected that the unconscious symbolism he had found in dreams would be fully supported in language. That his suspicions were remarkably accurate we can have no doubt. Our difficulty is not so much in finding evidence to support his view, but in selecting evidence which will be easily comprehensible, and, if possible, of a unified type. Where would such evidence be found? If the examples with which this paper began are any guide, we might be led to feel that the primitive forms of language are the most promising fields for enquiry—slang, colloquial speech, primitive languages, in fact, any field where language has been allowed to retain its spontaneous qualities to the full and has not been exposed to the formalized repressions of contemporary society.

These considerations led me to select the Polynesian group of dialects as a starting-point. These dialects are spread over a vast area of the Pacific, but are closely knit etymologically. Countless terms appear in almost identical forms and with almost identical senses throughout the islands of Polynesia. Another reason why study of these dialects is valuable is that they are completely remote from Europe. If it could be established that all dream symbols are directly mirrored in language, proof of this in Polynesian dialects would serve a dual purpose. In the first place, it would show the intimate kinship between language and dreams, and, in the second, it would show that the basic symbolism of the unconscious is not confined to any one section of the globe, but is universal. In addition, and now we are speaking especially from the linguistic viewpoint, it would give us a fresh approach to language, because it would show, as Hans Sperber (5) long ago suggested, that much of the origin of speech is concerned with sexual issues. In turn, this might prove of inestimable importance in exploring the nature of meaning which has currently reached a behaviouristic dead-end.

In the following material these points should be noted: The main evidence has been drawn from Polynesian dialects. Where this evidence has seemed a little weak, I have taken readily-available examples from other sources—e.g. orthodox English and English slang, orthodox French and French slang, Latin, etc.—but have made no attempt to deal exhaustively with these other sources. (It may be added, however, that these sources are just as productive as the Polynesian dialects dealt with below.) The method of presenting the evidence is to give Freud's symbolic equations first, in black type, and then add relevant evidence from Polynesian dialects to support these equations. The examples are grouped together in what may perhaps be best described as ' symbol-complexes ', i.e. in groups where many manifest symbols are found to refer to a single latent image.

Phallic Symbol-Complex

Penis (latent image) = **elongated object** (manifest symbol)

Mangarevan: *tore*, penis; a projection, a pole.

Maori: *were*, penis; young shoot of convolvulus.

kahi, penis; wedge.

Tahitian: *aero*, penis; tail of animal.

Hawaiian: *ule*, penis; tenon for a mortise.

Penis = weapon, instrument

Maori: *ure*, penis; stone axe, chisel.

tara, penis; point of a spear.

Mangarevan: *tara*, penis; horn, spine.
ure, penis; rudder.
Hawaiian: *ule*, penis; *ulepuaa*, auger, gimlet.

Penis = mountain, rock
Mangarevan: *tara*, penis; a mountain peak.
tore, penis; a tongue of land.

Penis = banana
Mangarevan: *tara*, penis; a kind of banana.

Penis = tail
Maori: *were*, penis; *weri*, tentacle, feeler.
Tahitian: *aero*, penis; tail of animal or sting-ray.

Penis = a suspended object
Maori: *were*, penis; to hang, be suspended.
Hawaiian: *ule*, penis; to hang, swing.
(cf. Latin, *penis*, penis, tail, ex *pendeo -ere*, hang, be suspended, and *pensilis*, dangler.)

Penis = child
Maori: *ure*, penis; *uri*, child.
(cf. English colloquialisms: *little one* and *little man*, penis.)

Penis = root (6)
Maori: *were*, penis; young shoot of convolvulus; *weri*, a root.
Tongan: *ule*, penis; *huli*, a root, plant, sapling.
Samoan: *ule*, penis; *uli*, taro sprout.

Penis = clitoris = projecting object
Maori: *tara*, penis; clitoris.
Samoan: *tola*, an erection of the penis; *toletole*, clitoris.
Maori: *tona*, clitoris; wart, excrescence.
Samoan: *tona*, clitoris; wart.

Penis = nose
Maori: *ai*, coitus; *aihu*, a salutation by rubbing or pressing noses.

Penis = lizard
Maori: *tara*, penis; *tuatara*, name of species of large lizard, a lizard-god; *ruatara*, a species of lizard.
(cf. Australian slang: *lizard*, penis.)

Vaginal Symbol-Complex

Vagina = cavity, opening
Maori: *puta*, vagina; hole, cave.
hika, vagina; *kohika*, a hole.
waha, vagina; entrance of a hole.
Samoan: *pu*, vagina; hole.
Marquesan: *pokopoko*, vagina; *pokoa*, a hole.
(cf. Latin: *cunnus*, vagina; *cuniculum*, hole, mine.)

Vagina = crack, split
Maori: *tore*, vagina; *torere*, cleft in hills, an abyss.
tapa, vagina; split, cut.
Samoan: *maisi*, vagina; split, cracked.
Hawaiian: *pukapaa*, vagina; *puka*, crevice.
(cf. Latin: *cunnus*, vagina, split, cut. English and U.S. slang: *gash*, *crack*, *split*, vagina.)

Vagina = shell
Samoan: *pu*, vagina; a shell.
Hawaiian: *puao*, orifice of womb; *pu*, a shell.

Vagina = mouth (lips)
Maori: *waha*, vagina; mouth.
puapua, vagina; *puaha*, mouth of river.
Samoan: *fa'a-gutululu*, vagina; *gutu*, mouth.
Fiji: *gusu-nimaga*, lips of vagina; *gusu*, mouth.
maga, vagina; *mama*, to chew.
Samoan: *laufu*, lips of vagina; *lau*, lip.
tamu, vagina; *tame*, to smack the lips.
Hawaiian: *kapa*, lips of vagina; lips.

Vagina = eye
Hawaiian: *ula*, vagina; eye.
Tahitian: *verevere*, vagina; eyelids.
Samoan: *mafela*, vagina; *fela*, eye.
Maori: *kiritore*, vagina; *toretore*, inflamed eyes.
Fiji: *vulua*, pubic hair; *vuluvulukanimata*, eyelashes.

Vagina = ear
Maori: *toke*, vagina; lobe of ear.

Vagina = nostrils
Hawaiian: *pukapaa*, vagina; *pukaihu*, nostrils.

Vagina (womb) = oven
Maori: *taowahie*, vagina; *tao*, to bake, cook.
hapu, pregnant ; *hapi*, native oven.
pokopoko, vagina; *pokokohua* (literally, ' vagina-oven '), an insulting expression.
Maori: *hanahana*, womb; Tahitian: *pahana*, cooking.

Vagina = container
Maori: *pokopoko*, vagina; *hapoko*, pit used for storing vegetables.
waha, vagina; middle of a seine net.
Samoan: *pu*, vagina; shell.
(cf. Latin: *alvus*, womb, *alveus*, boat; *cunnus*, vagina, *cucuma*, cooking pot, kettle, *cumera*, chest, box. U.S. slang: *bag*, *basket*, *can*, *fish pond*, *hot box*, vagina.)

Vagina = anus (see Anal Symbol-Complex)
Maori: *tore*, vagina; *kotore*, anus.
Samoan: *pu*, vagina; anus.
Hawaiian: *puukole*, mons veneris; *okole*, anus.
(cf. French slang: *cul*, vagina, anus. Latin: *cunnus*, vagina, *culus*, anus. English slang: *scut*, vagina, anus.)

Vagina = cat
Maori: *tore*, vagina; cat (modern).
(cf. examples at beginning of this paper.)
Vagina = landscape
Samoan: *lae*, vagina; country without trees.
Vagina (etc.) = **flowers, ornaments**
Maori: *puapua*, vagina, mons veneris; *pua*, flower, bud.
remu, menstruous cloth; decorative feathers; fringes of a mat.
(cf. English, U.S. slang: *pansy*, *buttercup*, *lily*, a homosexual male. English slang: *flowers*, menses; *cherry*, virginal. French slang: *avoir les peintres*, to have menses. Orthodox English: *deflower*, *defloration*, as applied to a virgin.)

Coital Symbol-Complex

Coitus = play
Maori: *nene*, pleasure in coitus; *whaka-nene*, to jest, sport; (*maunene*, vagina).
Mangarevan: *ua*, genitals; to play at ball.
(cf. Lithuanian: *žáidžiu*, to coit; to play.)
Coitus = speech (7)
Maori: *pa*, to coit; to speak with.
Samoan: *fai*, to coit with; to say, speak.
Hawaiian: *kaupili*, to coit; *pili* to agree together.
(cf. coital senses ascribed to English words: *conversation*, *criminal conversation*, *correspondence* and *intercourse*. Spanish: *conversar*. German: *Umgang* and *Verkehr*.)
Coitus = violent action
Hawaiian: *lapa*, coitus; to jump or spring about.
Maori: *mahimahi*, to coit; *mahi*, action, work.
kotiritiri, coitus; the movement of a piston (modern).
whaka-eke, to coit; attack, rush on.
Moriori: *maka*, coitus; Maori: *maka*, to throw.
(cf. Latin: *futuo -ere*, to coit with, which has same origin as *fustis*, a cudgel, and *fustigare*, to beat with a club. English slang: *f....k*, ex German *ficken*, to strike; *knocking-shop*, brothel; *bang*, *knock*, to coit.)
Coitus = rubbing
Maori: *hika*, to coit; to rub.
Samoan: *moetolo*, to coit; *tolo*, to rub sticks together for fire.
Malagasy: *lomy*, coitus, and Nguna: *roromi*, to love; Samoan: *lomi*, to rub, press, and Paumotan: *roromi*, to rub, press.
Coitus = fire
Maori: *hika*, coitus; to kindle fire.
ai, to procreate; *ahi*, fire.
ure, penis; *kaureure*, a stick used for producing fire by friction.
Paumotan: *honi*, coitus; *hogi*, to kindle fire.
Samoan: *moetolotolo*, to coit; *tolo*, to rub sticks together for fire.
Fiji: *sauka*, to coit; hearth.
Coitus = tilling of soil
Mangarevan: *aka-tupu*, to conceive children; to fertilize land.
Maori: *mahikino*, vagina; Hawaiian: *mahi*, a cultivation, planting.
(cf. English: *husbandman*, *husbandry*.)
Coitus = eating
Maori: *kaikaiatara*, to coit; *kai*, food, to eat.
Samoan: *fa'a-aiga*, consummation of marriage; *'aiga*, act of eating.
Paumotan: *apuapu*, to be pregnant; Maori: *apu*, to eat.
Hawaiian: *ipo*, to coit; *hoo-ipoipo*, to make lascivious gestures while eating.
(cf. Orthodox English: *sexual appetite*.)
Coitus = climbing
Maori: *whaka-eke*, to coit; *eke*, to climb, mount, go up.
Coitus = flight of bird
Maori: *aroha*, to love; *aroharoha*, to flap the wings.
Tongan: *ofa*, love; *lofa*, to fly, hover.
Samoan: *apa*, coitus; Maori: *kakapa*, to flutter, flap the wings.
(cf. German: *vögeln*, to coit; *Vogel*, a bird.)

Anal Symbol-Complex

Anus = eye
Hawaiian: *okole*, anus; *ukokole*, inflammation of the eye; *makakole*, sore-eyed.
Maori: *kotore*, anus; *toretore*, having sore eyes.
(cf. Spanish: *ojo sin niño*, ' eye without a pupil ', anus. English slang: *blind eye*, *dead eye*, anus. U.S. slang: *eyedoctor*, *Dead-eye Dick*, a pedicator.)
Anus = dark colour, stain
Tongan: *hilo*, anus; *felo*, yellow.
Hawaiian: *kio*, excreta; *kiokio*, anything spotted or variegated.
Maori: *wheru*, stain of excreta; *whero*, red, red-brown, yellow.
(cf. Australian slang: *brown*, *old brown windsor*, *tan-track*, anus. U.S. slang: *brown*, to pedicate; *browning*, pedication.

SCANNED 43 of 84

Anus = vagina
See under Vaginal Symbol-complex.

Anus = ring
Mangarevan: *pitore*, anus; ring.
(cf. Latin: *anus*, anus, ring; *anulus*, anus, ring. English slang: *ring*, anus.)

Excreta = soil, dirt, etc.
Hawaiian: *lepo*, excreta; dirt, clay, dust, earth.
kio, excreta; dregs, lees.
kukae, excreta; dirt, filth.
Mangarevan: *repo*, excreta; dirt, dirty.
Samoan: *tae*, excreta; *taetuli*, wax in the ear; *taetafi*, rubbish in a river; *taefe'e*, black vomit.
Tongan: *tae*, excrete; *taele*, sediment.
Macassar: *tai*, excreta; rust.

Excreta = exudations
Maori: *tutae*, excreta; *tae*, gum from tree.
Samoan: *tae*, excreta; *taetuli*, wax in the ear.
Tongan: *tae*, excreta; *faka-taetae*, to spit.
Marquesan: *tutae*, excreta; *kae*, spittle.
Malagasy: *tay*, excreta; *taiadelo*, nasal mucus.
Tahitian: *tutae*, excreta; *taetae*, a running sore.
Tongan: *tuu*, to excrete; a white watery substance in the eye.

Excreta = products
Hawaiian: *kukae*, excreta; *kukaepele*, sulphur, ' excreta of Pele ' (Goddess of volcanoes).
Paumotan: *tutae*, excreta; *tutaepere*, sulphur, ' excreta of Pere ' (Goddess of volcanoes).
Tahitian: *tutae*, excreta; *tiataeatua*, still-born children, ' excreta of the gods '.
Maori: *tutae*, excreta; *tutae-a-Matarua*, discoloured sea, ' excreta of Matarua ' (a deep-sea monster of Maori mythology); *tutaekoka*, a flaw in greenstone, ' excreta of the birds '; *tutaewhetu*, phosphorescence, ' excreta of the stars '.

Excreta = semen
Maori: *paranga*, excreta; *parapara*, semen, *parahika*, semen.
Fiji: *ci*, to break wind; Tonga: *hi*, semen.
(cf. Latin: *foria*, excreta. Greek: *θορός*, semen.)

Excreta = menses
Tahitian: *tapahi*, diarrhœa; menses.
Mangarevan: *tiko*, to excrete; to menstruate.
tikotutae, to excrete; *tikitoto*, menses.
(cf. Latin: *bubino*, menses; related to Sanskrit, *gutha*, filth, Old Bulgarian, *govino*, excreta.)

Excreta = smearing, etc.
Samoan: *sava*, excreta; daubed (with filth).
Hawaiian: *palahi*, diarrhœa; *palahea*, to daub, besmear; *hoo-pala*, to daub; *hopala*, to paint.
Maori: *paranga*, excreta; *parahanganui*, to smear.
(cf. Latin: *merda*, excreta, ex *(s)meu* = spread, smear, which is original form of *mucus* and to which is related English *smut*, *smudge*, *muck*, *mud*. Latin: *stercus*, excreta, ex *ster-*, spread, smear; *spurcus*, dirty, foul, ex *(s)peu-*, spread, smear.)

Excreta = food
Maori: *tutae*, excreta; *tutaetara*, a kind of sweet potato.
roke, excreta; *rokeroke*, a kind of potato.
paranga, excreta; *parare*, food.
Fiji: *benu*, excreta; refuse of food.
Tahitian: *para*, excreta; particles of food.
Hawaiian: *palahi*, diarrhœa; *palahea*, dirty food.
(cf. French slang: *etron*, excreta, *tronçon*, a piece of meat, fish; *crotte*, excreta, chocolate, sweets; *pet*, fart, *pet de nonne*, ' a nun's fart ', fritter.)

Excreta = goods
Maori: *whaka-reinga*, a dungheap; *reinga*, a thing much desired.
Maori: *otaota*, to excrete; Tongan: *gaotaota*, goods, chattels.

Excreta = a child
Maori: *tutae*, excreta; *tahae* (filth), a young person.
Tahitian: *tutae*, excreta; *tiataeatua*, still-born children, ' excreta of the gods '.

Excreta = penis
Mangarevan: *repo*, excreta; Paumotan: *repo*, (dirt), penis.
Moriori: *pia*, diarrhœa; Marquesan: *pia*, penis.

Excreta = speech (see **Flatus = speech**)

Flatus = blowing
Maori: *pihau*, flatus; *hau*, wind.
pupa, to break wind; *pu*, a wind instrument; *putorina*, a flute; *putara*, a shell trumpet, a gun (modern).
te, to break wind; to crack, snap; an explosive report.
Samoan: *taepu*, to break wind; *pu*, a trumpet shell.
Hawaiian: *hio*, flatus; a wind.
kio, to break wind; to blow on a pipe.

Flatus = speech (also **Excreta = speech**)
Hawaiian: *hopupu*, puffed up with wind as

bowels; *pu*, to come forth as words from mouth.
lepo, excreta; *leo*, voice, language.
Samoan: *pu*, anus ; (Maori: *pupa*, to break wind); Hawaiian: *pu*, to come forth as words.
Tahitian: *titio*, to excrete; *faa-tio*, to use contemptuous speech.
para, excreta; *parau*, speech, to speak.
Maori: *paranga*, excreta; *parare*, to speak loudly; *parau*, a lie.
Hawaiian: *palahi*, diarrhœa; *palale*, to speak indistinctly; *palau*, a lie.
Mangarevan: *koekoe*, a noise in the intestines; *aka-koekoe*, to speak with a shrill voice.

Anality = sadism
Hawaiian: *kae*, anus; contempt, to spurn.
Tahitian: *tutae*, excreta; *taehae*, cruel, wild, savage.
Paumotan: *tutae*, excreta; *taehae*, tyrannical; *arikitaehae*, a tyrant.
Samoan: *'ino*, excreta; *'i'ino*, a contemptuous interjection.

Anality = meanness
Maori: *tutae*, excreta; *taehae*, stingy, mean.
hakio, diarrhœa; *hakere*, stingy, mean.

Anality = evil
Hawaiian: *ino*, excreta; bad, wicked.
ho-ino, to befoul; to curse.
Tongan: *kinohaa*, excreta; Rarotongan: *kino*, evil.

Anality = sacredness
Tahitian: *turuma*, a dunghill; a sacred place.
Maori: *tuaahu*, a dunghill; a sacred place.
tiko, to excrete; *tiki*, an image of a deity.

Symbols Related to Penis Products

Urination = fluids
Fiji: *mimi*, urine; to run in a stream.
Mangarevan: *mimi*, urine; to percolate, filter through.
Hawaiian: *mii*, penis, urethra, a place for urination; *mio*, to flow.
Samoan: *ligiligi*, to urinate; *ligi*, to pour.
(cf. English slang: *to leak*, *make water*, *pump ship*, to urinate.)

Urination = semen
Maori: *tatau*, urination; *tatei*, semen.
(cf. Latin: *urina*, urine, semen.)

Semen = other fluids
Samoan: *vavale*, semen; phlegm, mucus; snail slime.
Maori: *tehe*, semen; *tahe*, menses; *whaketete*, to milk
tatei, semen; *tatau*, to express juice.

Semen = courage
Maori: *parahika*, semen; courage, ardour.
(cf. U.S. slang: *spunk*, semen, courage.)

Castration Symbol-Complex

Castration = cutting
Hawaiian: *kahe*, to castrate; to cut, to shave.
Mangarevan: *tehe*, to castrate; to cut well.
(cf. Latin: *castrare*, to castrate, to prune, lop.)

Castration = hair-cutting, baldness
Hawaiian: *kahe*, to castrate; to shave; *kahi*, to comb the hair.

Castration = female genital (i.e. that which is castrated)
Maori: *poka*, to castrate; a hole; Marquesan: *pokopoko*, vagina; *pokoehu*, virgin.
Tongan: *boka*, to castrate; *boko*, opening, aperture.

Shame, evil (? for castration) = vagina
Maori: *mahikino*, vagina; *mahi*, work, + *kino*, evil, misfortune, wickedness.
anahara, vagina; *ana*, cave, + *hara*, sin.
toke, vagina; an omen of death and disaster.
(cf. Latin: *pudendus*, shameful, and English use of *pudend* or *pudendum*, the genitals.)

Symbols Relating to Masturbation

Masturbation = pulling
Hawaiian: *uu*, to masturbate; to stretch.
(cf. English slang: *pull off*, to masturbate.)

Masturbation = beating
Tongan: *tukifulei*, masturbation; *tuki*, to beat, strike.
(cf. English slang: *to flog* (oneself), to masturbate.)

Masturbation = drawing off fluid
Maori: *whaka-te*, to masturbate; to milk, squeeze fluid out of anything.
Hawaiian: *uu*, to masturbate; *u*, breast of female.

Isolated Symbols

Death = journey
Maori: *haerenga*, journey; death.
Tongan: *hala*, a path; death (applied to a king).
Samoan: *ala*, a path; a bier.
(cf. English: *pass away*, *depart this life*, *go home*, *go before*, *pass on*, to die.)

(Mother) vagina = spider

Maori: *pungawerewere*, a spider; *werewere*, vagina, womb.
Tahitian: *puaveravera*, a cobweb; *veravera*, vagina, womb.

Womb = birthplace
Hawaiian: *ewe*, place of one's birth, homeland; *ieiewe*, womb.

Female breast = penis
Maori: *u*, breast; *ure*, penis.
Hawaiian: *u*, breast; *ule*, penis.
Mangarevan: *u*, breast; *ua*, penis.

Breast = hill
Hawaiian: *puu*, a hill; *puuwaiu*, the breast.
Mangarevan: *puke*, a nipple-shaped peak.

Mons veneris = hill
Maori: *puke*, hill; mons veneris.
Hawaiian: *puu*, a hill; *puukole*, mons veneris.
Malay: *bukit*, a hill; *puki*, mons veneris.

Testicles = small (round) objects
Maori: *whatu*, a testicle; a stone, hailstone, pupil of the eye
repe, a testicle; a kind of potato.
(cf. English dialectal: *cob*, testicle, a lump. English slang: *balls*, *stones*, testicles. U.S. slang: *berries*, *nuts*, *seeds*, testicles.)

Children = small animals, vermin
Maori: *potiki*, child; *potipoti*, an insect.
Mangarevan: *potiki*, child; *potipoti*, an insect.
Hawaiian: *pokii*, child; *poki*, worm, crab.

Sucking = kissing
Samoan: *miti*, to suck; to kiss.
Mangarevan: *miti*, to lick; *mito*, to kiss.
Tongan: *hutu*, breasts; *uma*, to kiss (the operative syllable is *u*).

Nudity = a state of being mateless
Maori: *takahore*, a naked person; a widow, widower.
Tongan: *takahe*, naked; unwed.
Tahitian: *tahaa*, naked; *taa*, unwed.

Mother = earth
Maori: *Papa*, the Original Mother; the Earth.
(cf. German: *Mutter*, mother, sediment. Dutch: *moeder*, mother, *moer*, lees, dregs. Greek: γραῦς, old woman, dregs. English: *Mother Earth*.)

It would have been possible to add considerably to this list, but it might have served to do little more than obscure the main issue. The important point is this: Polynesian dialects are found to contain linguistic associations which directly parallel dream symbolism. Enough scattered examples have been supplied from other languages to suggest that, if we probe deeply enough, we shall find similar evidence from other sources.

This finding is perhaps of more salutary importance to philology than to psychoanalysis, because psycho-analysts have long suspected these things, whereas the orthodox philologist has pushed them aside as being unworthy of his attention. We are certainly led to pay greater respect to Sperber's view that language has sexualized origins. If one is not mistaken, it would seem that infantile or primitive experiences focus attention on pleasure-giving functions and that the exterior world is then arranged in terms of those functions.

Perhaps a moment could be spared to examine some linguistic material which may clarify this matter. This material is taken from Pidgin English as spoken in New Guinea. Pidgin English took its original form with the advent of European traders and adventurers to the Southern Seas more than a century and a half ago (8). Most of the words in Pacific Pidgin were originally English. A few German, French and even Latin words are incorporated in it, together with some native terms, but the main basis of it is English. Many of these English originals are not easily recognizable to-day, especially when written, but if it is noted that Pidgin words are basically the sort of mutilations a child would make, it is possible to translate most of them without difficulty. The point to be made is this: English words were originally adopted by the natives in what must be regarded as approximately orthodox senses. A regressive tendency has developed for the natives to apply these words in ways which directly parallel dream symbolism.

For example, *bokis*, the Pidgin version of ' box ', is now also applied to the female genitals; *dati*, a mutilation of ' dirty ', is now used to denote excreta and scraps of tasted food; *goapim*, ' go up ', meaning to climb or mount, now also means to coit; *plei*, the Pidgin version of ' play ', now also means to coit; *stilim*, a mutilation of ' steal ', is now also used to mean to commit adultery; *win*, the Pidgin for ' wind ', is now applied to anal flatus.

How much of this is due to the natives' own associations of ideas and how much to the direct influence of white men is, of course, impossible to gauge. The simple fact is that these are the sort of symbolic equations we have examined in Polynesian dialects, except that

they are in reverse. That is, instead of originating in emotionally-cathected ideas or images, they have been acquired in a seemingly innocuous way, yet have speedily developed emotionally-cathected associations. We begin to suspect that this could not occur unless language possessed some unconscious characteristics of which we are not commonly aware.

In another paper (9) I have pointed out that word-taboos, both in current society and in primitive tribes, are concerned not with erasing certain words from the vocabulary, but with preserving those words in their most highly-affective forms. The most ' vulgar ' or ' objectionable ' words, as far as modern society is concerned, relate to the sexual or excretory functions. Censorship serves to prevent these words escaping into popular speech, where their sense-contents would be widened and their affective associations would tend to be dissipated. We do not need to inspect these tabooed words at great length to realize that they are linked directly with the latent images listed above.

Now, if the unconscious motive behind word-taboos is the protection of affectively significant images, it becomes clear that we must view these so-called vulgarisms in a new light. Instead of being linguistic excrescences, peripherally emerging in language, these words stand at the core of language. They are the beginnings from which language takes its figurative form, just as the images linked with these words are the foundations from which dreams take their form. They are the axis on which language turns—not merely one language or one group of languages, but all languages.

What right has one to say this? First, there is the evidence from language itself; second, there is the parallel evidence from dreams; third, there is the evidence from psychoanalysis which shows the ego-centric nature of all learning. The ' learning ' to which I refer, of course, is the experience of pleasure-giving bodily functions in childhood. As E. S. Hartland comments in his *Ritual and Belief*: ' The personal element . . . forms everywhere the basis of language. Hence it was impossible to interpret external phenomena in any other than personal terms.' Primary experiences of pleasure-giving bodily functions—oral, anal, urethral and genital—serve to bequeath to the individual a series of unconscious images which he never throws off. These images form the associative bases for all his later conquests of reality. Since language is one of the main instruments for this conquest, one can scarcely be surprised to find that it bears multitudinous traces of man's infantile fantasies.

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ON THE TERMINATION OF ANALYSIS[1]

By ANNIE REICH, M.D., New York

Astonishingly, the topic of termination of analysis has very rarely been the subject of psycho-analytic investigation. Obviously it represents a great number of theoretical, clinical, and particularly technical problems. Of the many I should like to take up only a special one: the transference, or, more cautiously expressed, one typical transference situation as it exists at the time of the termination of the analysis. Before doing this, however, I should like to turn first to the existing literature. To my knowledge there are only two papers that deal with this subject: Freud: 'Analysis Terminable and Interminable' and Ferenczi: 'The Problem of Termination of Analysis.' These two papers represent an interesting contrast in their outlook, we might say in their emotional atmosphere. Freud's paper is full of wisdom and scepticism. He is reviewing as if for the last time the therapeutic results of his work. He is pointing out everything that is uncertain, he is revealing whatever he considers the limitations of therapeutic effectiveness. Ferenczi, on the other hand, is full of optimism. He gives us an idea of what he considers a completed analysis; he gives us a wealth of technical advice and clinical details which are pointed out as the preconditions for a completed analysis. Here two aspects are most interesting: (1) The analysis of character traits, of ego behaviour patterns which developed as *protective* automatisms in the course of instinct repression and have to be retraced in the analysis to their origin. The rigid crystallization of character has to be dissolved again if a real re-education of the patient is to be achieved. This will lead to infinite inner freedom combined with a complete ego control. For this purpose Ferenczi pleads for a thorough analysis of facial expression, postural peculiarities and so on, and proposes the imitation of the patient as a suitable method for bringing these behaviour patterns to the attention of the patient and making their analysis possible. Character was here understood for the first time, though not elaborated upon, as a defence which has to be analysed just like other more obvious forms of resistance. (2) The analysis of hidden distrust against the analyst, the analysis of tendencies to test the analyst's patience and sincerity and the frequent desire to discover hidden negative counter-transference expressions in the analyst. This onslaught the analyst has to be able to meet, to analyse and utilize for the analysis. Ferenczi touches on problems which at the time of the publication of his paper (1927) were beginning to become more and more the centre of discussion: Analysis of defences, character as defence, deeper understanding of ego functioning, etc., problems which were all based on Freud's new insights into the nature of the ego.

The application of this more thorough technique, Ferenczi indicates, enables the analyst to bring an analysis to full completion. A really fully analysed case is characterized by an extensive new formation of the whole character —as mentioned before—and full overcoming of the castration complex in all its involvements.

The contrast between this positive outlook and Freud's paper which was published in 1937, just ten years later, is indeed striking. In praxis, Freud points out, it is rather obvious what the conditions for termination of the analysis are: the patient has to have lost all his symptoms, inhibitions, anxieties. All his repressions have to be undone. This implies, as is mentioned elsewhere in Freud's writings, that the blank spots caused by infantile amnesia have to be filled out, the childhood history has to be reconstructed. As a means to this aim the transference has to be solved. The therapeutic result which we desire is expressed best in Freud's own words: Where Id was, Ego should be.

These results, of course, we are not always able to achieve. Too violent intensity of instinctual demands or too severe pathology and weakness of the ego frustrate our efforts.

[1] Read at a meeting of the New York Psycho-Analytic Society, April 12, 1949.

Furthermore: our therapeutic aims go beyond achieving ego control only for the present time. We hope to establish a condition that makes relapses impossible. Here Freud is extremely sceptical. The balance of power between instinct and ego, he stresses, is a very labile one. Any later shift in cathexis may disturb it. Instincts may gain in strength, as happens biologically in puberty or menopause. Reality frustrations may cause recathexis of already relinquished infantile impulses. Illness, age, frustrations and so on may weaken the ego, and thus preconditions for relapse and new illness arise. Freud discusses at length whether it is possible to prevent such later incidents by ' waking sleeping dogs ', that is, by analysis of instinctual conflicts which are not actual but only latent ones. He decides that this is not feasible.

It may be that Freud here takes too pessimistic a view. The greater importance which the analysis of the ego has gained during the last few years has sharpened our faculties of observation and understanding. We have learned to discover in peculiarities of behaviour patterns, in character traits and in the detailed analysis of defence mechanisms, the signs not of course of really absent, but of latent conflicts. We have learned to unearth indications of latent negative transference, of hidden aggressive trends, and so on, as we have mentioned, which, if not analysed, will endanger the later balance. Does not the analysis of these warrant a greater degree of reassurance against relapse than was assumed before? Or do we yield to a rather obvious temptation to wishful thinking, when we consider Freud too sceptical and are most interested in increasing our technical skill and deepening our understanding, and tend to attribute our therapeutic failures to our not yet having reached the necessary and achievable degree of perfection and subtlety? Do we, together with Ferenczi, harbour a concept which, by the way, is only vaguely implied and never directly expressed in Ferenczi's papers, that an ideal, an absolute state of health can be achieved, that a patient can be so completely analysed that nothing remains hidden and no traces of neurosis are left and thus no relapse is possible? Such a concept, of course, would appeal to the narcissistic omnipotence fantasies of the analyst.

Freud certainly is free of such wishful thinking. He enumerates a number of elements which frustrate the therapeutic efforts. He mentions particularly overintensity of instincts, which is frequently combined with weakness of the ego. This overintensity of instincts may be constitutional. Beyond the economic factor one frequently finds here what can be called stickiness of the libido, an unwillingness to give up once cathexed objects, and furthermore the so-called ' id-resistance ' that is a rigidity of libido, an unwillingness to give up old libidinal patterns and to accept more adult substitute gratifications. These three elements are frequently expressed in the form of uncontrollable and un-analysable transference demands: *Suppenlogik* and *Knödelargumente*, as Freud called them in an earlier publication. We are faced here with early and deeply ingrained instinctual patterns which are just not to be modified.

The same rigidity can be found in the realm of the ego, which can be either thoroughly and early distorted by the result of defensive struggles or may even be constitutionally burdened. Freud here envisages the possibility of hereditary transmission of ego-behaviour.

In contrast to Ferenczi's optimistic attitude Freud considers castration fear, the penis envy of women and the resistance against submission in men, as something which in certain cases is unchangeable like ' grown rock '.

Finally he talks of overintense conflicts between ego and superego, of an unconquerable intolerance against one's instincts which may be caused by the diffusion of instincts, by an enormous amount of aggression which is turned against the self and results in a tendency towards conflict.

In the past, it happened again and again that an idea at which Freud hinted in one of his papers became the subject-matter of intense investigation and also speculation for many. In his paper, ' Analysis Terminable and Interminable ', Freud emphasizes that the conditions for failure of analysis should be studied more thoroughly. Unfortunately, this has not up till now been done. Indeed, in this paper many questions are touched upon which are still open problems. For instance, the last mentioned precondition for failure, the tendency towards conflict as an expression of internalized aggression or death instinct, represents a concept of the greatest theoretical importance, the discussion of which goes beyond the scope of this paper.

This enumeration of unconquerable difficulties makes explainable many of our therapeutic

limitations, which we have learned to accept. We do not hope that by analysis we can produce perfect human beings. We are content when we can free a patient from his symptoms and anxieties, when we can make him capable of adult object relationships and enable him to function in his work and adjust to his reality. We are happy if we can help him to free old sublimations and to build up new ones. But we do not expect too much in this respect. We consider it as a sign of health if the patient is capable of accepting his own limitations.

Finally, I come to my subject proper. Being more modest in our demands, we do not expect our patients to be able completely to give up their transference expectations, and we take it for granted that a residue of infantile cravings will continue to exist. Even at the end of analysis, some elements of transference are traceable. Here, too, Ferenczi is too optimistic. He believes that the transference can be so completely dissolved that the analysis finally ' dies from exhaustion '. Neither for the patient nor for the analyst is it necessary ' to give notice '. When the patient declares his intention to leave the analysis one must always be afraid that by going he wants to keep something neurotic covered. It is not right for the analyst to terminate the analysis, because so long as the patient wants to come he belongs in analysis. In the ' ideally completed analysis ' the patient severs himself slowly but decidedly from analysis. This process can be described as follows: the patient becomes slowly convinced that in analysis he only preserves new and still fantastic means of satisfaction that do not bring him anything in reality. As soon as he has overcome the mourning over this insight he looks out for more and more realistic methods of gratification. The frustration in the analytic situation which he tried to avoid by holding on to the ideas of possible fantastic gratification is a repetition of the infantile frustration situation which was behind the symptoms. By this insight a real overcoming of this situation is achieved.

Ferenczi here clearly recognizes the nature of the infantile fantasy which ties the patient to analysis. From my own experience I can confirm this observation. Even after the transference has been well analysed and its important infantile sexual elements have been overcome, even after the neurotic symptoms have been given up, the relationship to the analyst is still not a completely mature one. We have to state that the transference is not completely solved. The analyst is still an over-important person for the patient, and is still the object of fantastic expectations. As mentioned before we do not expect to be able to free our patients completely from their infantile fixations. But apart from these individual fantasies, there are certain attitudes typical of all patients. In nearly all cases which I have analysed there remained a wish to be loved by the analyst, to keep in contact with him, to build up a friendship. Further analysis of these wishes proved them to be derivatives of an early relationship with the parents, mostly diffuse oral pregenital in nature, but aim-inhibited and thus acceptable to the ego. The analyst was still seen as a person endowed with special power, special intelligence and wisdom. In short, to a certain degree he is still seen as partaking in the omnipotence which the child attributes to the parents. Of course, there are great individual differences. If, for instance, an analysis ends with a free break-through of genitality up till then inhibited and the establishment of new and important object relationships, the transference may indeed be completely decathexed and the analysis may be readily given up. But here one must be a little cautious. Sometimes a patient throws himself into such a relationship as a means to overcome an unanalysed disappointment about the loss of the analyst. This is a negative attitude in relation to the termination of analysis, just as we see a negative type of transference frequently as a defence against possible rejections in the course of analysis.

At the termination of the analysis of adolescents I also have seen great readiness to give up the analyst. In all these cases a full-blown transference had never developed. Certain secrets were never revealed—the analysis as such had been incomplete. Similar situations are probably found with children.

In any case, I have not frequently seen such an easy giving up of analysis, such an ending of a transference by ' natural exhaustion ' after really deep analysis. Patient and analyst agree that there is no need for further analysis, nevertheless the patient has a feeling of loss at the time of the termination which is overcome only slowly in the course of time. It is possible, though, that with my patients there was always this residue of unsolved transference because we hardly ever had ' endless time ' at our disposal, as Ferenczi postulates as opportune for the ideal situation.

In most cases a slight pressure has to be used to overcome a certain ' stickiness ' of the libido. Only reluctantly does the patient give up the loved object, the analyst whom he had previously charged with so much emotion. Ferenczi is, of course, right when he compares this loss to the original infantile frustration, and undoubtedly the analysis of this repetition situation proves very helpful.

I remember the case of a student who came to me for his training analysis several years after the successful completion of a therapeutic analysis with another analyst which had lasted three years, and had freed the patient from a number of disturbing symptoms and helped him to adjust to various difficult life situations. His description of his reaction to the termination of his first analysis was quite revealing: ' I felt as if I was suddenly left alone in the world. It was like the feeling I had after the death of my mother (the mother had died during the early adolescence of the patient). I tried with effort to find somebody to love, something to be interested in. For months I longed for the analyst and wished to tell him about whatever happened to me. Then slowly, without noticing how it happened, I forgot about him. About two years later, I happened to meet him at a party and thought he was just a nice elderly gentleman and in no way interesting.'

The description the patient gives here is indeed like the description of a period of mourning. It takes time until the libido is withdrawn and new objects can be cathexed. Needless to say, the object which is given up here is an infantile one. One could understand this mourning reaction as a specific transference situation, for instance, in the case mentioned, as a re-living of the death of the mother. But it seems to me that this reaction, though frequently to a slighter degree, is a typical one and is in no way conditioned by the experience of death in childhood. It appears to me as if in the analytic situation as such there are a number of factors which represent not only fantasy repetitions of childhood conditions but are the expressions of a specific actually existing relationship. That is to say, the analytic situation as such is an abnormal one, a unique relationship between two persons which necessarily causes the one partner to produce infantile reactions and to hold on to infantile behaviour in relation to the other. The analyst has listened for two or three or more years with unending patience and unvarying interest to the patient's most intimate confessions. He has helped him through innumerable battles. Though he has not satisfied the patient's sexual desire, though he has not given the patient the type of love he wanted, he has given him nevertheless something very tangible: his unselfish attention. Through his interest the analyst has proved to the patient that his inner life is worth being looked at, being heard about. This implies some kind of primitive narcissistic gratification to the patient which, I believe, is the basis for the already described passive-oral attitude of the patient, his hope of further love and his tendency to see the analyst as a powerful parental figure.

We all know that in analysis the patient has to experience frustrations in the transference situation. But the somewhat sublimated passive infantile gratification already mentioned cannot be denied to the patient. The analyst cannot withhold it; it is the basis of our method. Here satisfaction has to be given.

Furthermore, we must not forget that the analyst was hardly ever a real person. Unknown and undescribed, he became the recipient of the patient's fantasies. The lack of reality around the analyst makes it impossible to see him with his foibles and weaknesses as an ordinary human being. He has given to the patient help, and beyond that the afore-mentioned infantile gratification. And as correction through reality is impossible, it is no wonder that the patient has a tendency to continue to see the analyst as an aggrandized figure and does not like to give up this gratifying relationship. He may even understand intellectually that further contact would preserve an unhealthy transference situation and condition later acting out. Thus he may understand why there should not be any further social contact with the analyst; but he does not like this.

Thus it appears to me inevitable that the termination of analysis should be felt as a loss, particularly by those patients who are not too happy with their life in reality and for whom it is not too easy to shift readily to other objects the libido invested in the analyst.

Nevertheless, in the course of time, after a really thorough analysis this shift does take place, and slowly the wish to hold on to the infantile relationship to the analyst is relinquished. It seems to me important to understand this sequence as a typical reaction to the analytic situation in order not to be too concerned about it and to be able to deter-

mine the suitable time for the termination of analysis. We do not have to be too worried about any lasting negative results of these residues of transference. As in mourning, a spontaneous recovery takes place, we might say a recovery from the abnormal situation of analysis.

With students who have the occasion to meet their analyst professionally after termination of analysis this process progresses faster. They have the opportunity to see their analysts in the frame of reality, and the magic omnipotent features of the relationship collapse more readily under these conditions and may be replaced by a mature friendship or a working relationship. The final solution of these last traces of transference can be considered as a final growing up of the patient.

Frequently, as Ferenczi mentions, hidden magic expectations are revealed only as a reaction to the planned termination of analysis; for instance, the tenaciously and secretly kept expectation of the woman patient that analysis in the end will supply her with a penis. To uncover such fantasies, it seems technically advisable to plan the termination of analysis several months ahead of time in order to have the opportunity of thoroughly working through this problem. A fixed date, unless, let us say, a summer interruption, or some event in the life of the patient, makes it inevitable, is better avoided, in order not to create too much pressure and anxiety. Frequently one experiences a flare-up of symptoms which had been overcome long before, or neurotic elements up to then unknown come to life. Frequently this flare-up can be understood as the effect of the aforementioned need to hold on to the analyst, who is, so to speak, to be blackmailed into continuing the analysis.

These dependent attitudes as by-products of the analytic situation as such have impressed various analysts, and some have advocated short analyses as a means to avoid this danger. I cannot agree with this conception. The short analysis leaves so many deeper problems unsolved and untouched that its disadvantage is greater than any gain from it. If I am correctly informed, the Columbia School has recently made this type of dependence the main theme of their transference analysis. It is with this innovation as with all other deviations from the classical theory and method: One element is put into the centre of the stage in order that other equally important ones may be dropped. If one analyses solely these vestiges of dependence one is likely to overlook other important features of transference.

It seems important in this connection to mention shortly certain counter-transference attitudes which may complicate the problem. Sometimes analysts have a tendency to terminate analyses too early. Apart from expediency motives, there is frequently a narcissistic need to achieve results quickly which cannot tolerate the slow pace of analytic work. There are others who have a need to end relationships with patients soon before a danger situation in regard to their own badly controlled homosexual urges can arise; others, on the other hand, cannot give up a patient and enjoy the dependency situation. These counter-transference difficulties, of course, should be eliminated in the analyst's own analysis. But the situation of ending an analysis is seldom one that comes to the attention of the training analyst, as we do not usually see our students so long. Of course, the underlying difficulty should show up in some other fashion.

So far I have mentioned only the termination of a successful analysis. We are, however, not always successful, or at least not completely successful. Frequently only in the course of analysis does it become obvious how deeply ingrained the anxieties are or how weak the ego, or how over-rigid and overstrong are the instincts. Only in the course of analysis is one faced with the failure of the attempt to solve these conflicts. Patients of this type are usually suffering severely, and a serious attempt to help is justified even if we fail to do so. Frequently we do not fail completely, but we can bring about partial mitigation of symptoms and strengthening of the ego. But the time comes when we have to face the fact that it does not make sense to go on. In these cases, it is my impression that a thorough working through of the reaction to the termination of the analysis as described above is not indicated. It is wisest, in these situations, to wait for a period when the ending of analysis seems to be least painful; when, for instance, suffering has subsided, when certain narcissistic gratifications are available. One could say with justification that this way of ending analysis is not really a psycho-analytic but a psycho-therapeutic one. It may be so indeed, but it seems to be the most painless procedure.

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TECHNIQUE OF TERMINATING ANALYSIS[1]

By EDITH BUXBAUM, PH.D., SEATTLE, WASHINGTON

A discussion on the technique of terminating analysis is necessarily dependent upon the question of what constitutes a ' terminated analysis '. This problem has been discussed in several papers and symposia. It has been pointed out that it is necessary to discriminate between a therapeutically satisfactory and an analytically satisfactory termination. In some instances therapeutic and analytic termination coincide; in others they differ. Freud (5) points out that only in cases of traumatic neurosis can analysis be considered terminable, i.e. analytic and therapeutic results are complete and identical. In contrast are character neuroses whose analyses are analytically interminable; for therapeutic purposes, however, we have to settle for certain results. In Jones' words (7): ' On the purely therapeutic side I would attach the main importance to the patient's subjective sense of strength, confidence and well-being. By well-being I mean of course the potential capacity for enjoyment and happiness, since the actual amount of happiness obtainable will not depend on internal factors only. This subjective sense signifies that more energy is at the disposal of the ego than there was previously, while there is correspondingly less cathexis of id and super-ego " positions " independent of ego control. The state of affairs can be described equally well in terms of greater freedom on the part of the ego or of greater self-control of the total personality. The two conceptions are synonymous; self-mastery means freedom for self-expression and freedom from internal compulsions. A harmonious conscience has to a great extent replaced the unconscious super-ego. The ego has expanded at the expense of the id and super-ego. The energy of the id is discharged towards the outer world via the ego and not independently of it. All these statements are merely different ways of saying the same thing.'

Jones says in a more explicit way what Freud said in a few words: ' The business of analysis is to secure the best possible conditions for the functioning of the ego; when this has been done analysis has accomplished its task ', or even more aphoristically: ' Where there was id there shall be ego.'

While there have been many discussions and papers on the problem of success and the therapeutic results of analysis, there are only a few remarks in the literature on the phase of termination itself, and even fewer on the technique of ending. Freud usually employed the method of setting a date for the termination of analysis, first used in the case of the Wolf Man, and this has been taken over by many analysts. He calls it ' a device for putting pressure on the patient '. For that reason he warns against using this means except in situations where one is sure of its effect. Once this means has failed and the analysis cannot be terminated in spite of it, the patient had better be sent to somebody else. ' A mistake once made cannot be rectified ; the saying that the lion springs once and once only must hold good here ' (Freud). Lorand evidently does not consider himself such a lion, and therefore prefers to set a date in the form of a casual suggestion, so that one can continue should the tentatively set date prove to be wrong. Ferenczi, at the time of his ' active technique ', concerned himself with termination techniques, advising the setting of dates, and demanding that patients perform tasks until then avoided, in order to shorten the therapy. A few years later (1927) he refuted his own ideas and felt that ' the correct way to terminate an analysis is one in which neither the patient nor the analyst gives notice; the analysis should so to speak die of exhaustion. . . . A truly cured patient detaches himself slowly but surely from the analysis; as long as he still wants to come, he is still in need of it. One could characterize this process of detachment also by saying the patient finally convinces him-

[1] Paper read at the Joint Meeting of the Psycho-Analytical Societies of Los Angeles and San Francisco, October 8th, 1949.

self that he used the analysis as a new yet fantastic means of satisfaction which however does not satisfy in reality.'

Annie Reich read before the New York Psychoanalytic Society a paper, still unpublished, ' On the Termination of Analysis ' (9). She considers Ferenczi's ideas over-optimistic. She holds that we cannot expect patients to give up their transference expectations completely and states that residues of their infantile cravings will continue to exist. Grotjahn and Simmel also noted that transference is often not entirely dissolved; they are, however, not satisfied with this state of affairs, because they consider it ' potential material for sickness '.

Alexander (1) advises termination prepared for ' by one or more preparatory interruptions ' which may have to be ' imposed ' at first. After a number of such interruptions in which assurance is given that the patient may return to treatment, ' termination of treatment will not be artificial, but will become a natural ending of the analysis '.

These few remarks on the technique of termination are concerned mainly with two problems: One is the ever-present problem of transference, and whether it constitutes a particular problem during the end-phase of analysis or not. The other is the question of timing, whether to set a date or not; this seems to be left mainly to the temperament and intuitive skill of the analyst. It seems to me that termination technique, like all technique, must evolve from our understanding of the patient's neurosis and his peculiar character structure. I would like to discuss a few end phases of analysis in their context with the total personality to illustrate this point.

A patient, a man of thirty-seven, came into analysis because his wife, who was in analysis, wanted him to be analysed. His own reasons for needing treatment were partly denied and partly unconscious to him, and were gradually revealed in the opening phase of his analysis. In the order in which he discussed them they were: marital conflict, migraine headaches, indecision, and, finally, premature ejaculation. The nucleus of his neurosis was briefly this: he could not decide whether he wanted to be a man or a woman. He was domineering in his marriage, acting the strong man while he masturbated with phantasies of being a woman. He had a tendency to submit to his superiors in his job and was afraid to make his own decisions for fear of antagonizing them. He was furious about his own cowardice, felt unable to express his hostility and aggression; the resulting symptoms of these conflicts were headache and premature ejaculation. The fact that the patient entered the analysis because his wife wanted him to was part of his neurosis. He avoided making a decision himself, let his wife do it for him, and then resented her, himself, me and the analysis for it. In his childhood he obeyed his father in the same way, foregoing any will of his own. After his father's death when the patient was twelve, his mother took on the same controlling rôle. She inherited his obedience and resentment against the father, which overlaid his œdipal feelings for her. The mother determined his career; his marriage was an attempt to break away from her by choosing a girl of the opposite type. His symptoms proved that he was unable to solve his problems.

Strong passive homosexual tendencies conflicted with aggressive masculine strivings. The identification with a woman—the mother—was his way of avoiding the dangers which he feared if he incurred the hostility of men. This solution was unacceptable and resulted in headaches and tormenting indecision. If he could get the sanction of a father-figure he could go ahead with whatever he intended to do; yet that very fact put him into a passive, obedient rôle towards that father-figure, resulting in a regression to his old passive-masochistic phantasies and in premature ejaculation.

According to this brief outline, we can expect a certain type of transference. The patient oscillated between seeing me as the mother with whom he feared to identify and the father whose judgments he tended to take over and whom he hated for it.

When the problems of the patient were seemingly worked through and his symptoms of headache and premature ejaculation had disappeared, we discussed terminating his analysis in six to eight weeks. It so happened that during this last stretch of the analysis the patient was offered a job; he had to decide about accepting it within a time limit overlapping with that of the end of the analysis as we had planned it. The patient was afraid that he might react to ending his analysis by making a wrong decision. He was therefore inclined to prolong the analysis until his decision was made. I had some doubts myself whether it was wise to let the patient leave the analysis in such a critical period of his life. In discussing

again the transference relationship of which he wanted to make use in making this decision, it was pointed out that in reality I had nothing to say in this situation, that the patient used me merely as a ' sounding-board ', projecting his own thoughts upon me. The patient then realized that it was a question whether to continue his analysis for an indefinite period until such time as he felt that he could decide these and similar problems for himself or whether he felt he could do so now. At any rate, to arrive at this particular decision was not the problem of the analysis. The patient decided to leave the analysis at the time which was originally set with the understanding that he would work out his plans alone. I assured him that I was interested and wanted to know what his decision would be; also, that he could resume his analysis if he felt the need for it then. The patient left the analysis and came back for one interview after a period of about two months to tell me what his decision had been and to say that he felt comfortable and in no need of further treatment.

The question that arose in connection with this way of terminating was whether the patient's symptom of indecision was sufficiently analysed or not. We remember that he started his analysis by having a woman make his decision for him. Indecision was an integral part of his neurosis, now part of his transference neurosis. It seemed to me that he was well able to drop this symptom provided the analyst did not prevent him from doing so. To allow him to continue his analysis until his decision was made would have had the effect of shattering the results of the analysis by implying that the analyst thought the patient was unable to decide. Even with analytic interpretation, the analyst's uncertainty would not have been counter-acted. The action of the analyst, namely to continue or discontinue the analysis, was at this point more important than any interpretation. It demonstrated to the patient that he could arrive at decisions independently, and also the analyst's faith in his ability to do so and her permission to be independent.

In watching one's own reaction in this instance, one can readily see what the counter-transference is: the patient presents himself as immature and dependent on the wise, foreseeing, almighty analyst, and the analyst has a hard time refusing to accept that very flattering rôle. It becomes less difficult when the analyst considers that the patient knows as well as the analyst that she is not ' wise, foreseeing, and all-mighty ' and would hate her, if she would accept this rôle, forcing him to continue in a child's rôle for a longer time than he needed to as his mother had done in his adolescent period.

The child analyst recognizes an old familiar pattern in this sort of relationship. The mother who refuses the child the right to grow up is the one who is herself truly dependent on the child for her satisfaction. In the case of this patient this was quite obvious. After the husband's death the mother transferred her feelings for him on to her son. The patient, being unable to accept that rôle, preferred to continue his part as the over-dependent and over-obedient son, denying and masking his œdipal feelings in this way. The request to be allowed to make his decision during a prolonged analysis has to be understood as a test for the analyst, not only whether she will allow him to make his own decisions but also whether she will finally permit him to have genital feelings or not. To continue the analysis would have had the meaning of denying him genital feelings, that is, genitals; it would have meant castrating him and destroying what had been achieved in the analysis. A child cannot become independent if the mother urges him to do things for himself while she continues to spoon-feed him. Likewise, a patient cannot make the step away from the analysis if the analyst holds him back.

The technique employed in this case shows some similarity to Ferenczi's active termination technique: the patient agreed to perform a task as a test for his cure. This is not very different from a technique which demands that the patient after sufficient working through do something which he has phobically avoided until then. By forcing himself to do the avoided thing, he convinces himself of its innocuousness in so far as it is actively dropping or being forced to drop a symptom. The more significant process, however, is in the use of transference and—as it seems to me—counter-transference.

Another example: Mrs. X came into analysis because of reactive alcoholism and unsatisfactory sex relations with her husband. In the foreground of her transference neurosis was her relationship to her mother. She felt her mother rejected her because she was a girl. Her drinking was an expression of her identification with her alcoholic father and brother; she then phantasied being a boy. In order to avoid homosexual relationships, she flew into promiscuous relationships with men. Sex relationships with

men, she phantasied, would provide her with a penis. When the patient was forced to give up her phantasy of ever becoming a man and of being accepted by the mother as such she returned to her original attempt of identifying with the mother, accepting the feminine rôle. This, however, according to her childhood memories, was tied up with her love for her father, and therefore brought on rejection and jealousy on the part of the mother; it meant for the patient having to choose life with her husband, child and home at the risk of antagonizing her mother by actively competing with her and eventually losing her love more than ever. This conflict was worked through in the transference, that is she identified with me while at the same time she was constantly afraid that I, like her mother, would reject her for doing so. When she broached the question of ending her analysis in April, I agreed with her that she might think of it. Then she wanted to leave in November when she would go on vacation. This date was chosen in contrast to my own vacation which the patient had rejected as a suitable time for ending the analysis, namely in June. It was, however, not so much the date as the fact that I was leaving her. She wanted to leave me instead of my leaving her. Then she decided that really there was no reason to spend so much more money and time on me which she could put to better use otherwise. We decided then that she should see how she would get along without me during my vacation provided she could come to see me once a week after that time. Later she reduced the frequency to once a month. The patient left the analysis about a week before I went on vacation, which means, of course, that she left me. She reserved an hour a month hence which she kept in order to say that she was getting along all right, and did not feel that she needed to make another monthly appointment. She wanted to be sure that I would see her if she felt the need for it. She did not return.

What seemed to be important in the process of ending this analysis was that the patient made the decision and set the time, being able to return to me when she wanted with no rejection whatsoever on my part. Every condition of ending was accepted by me. I allowed the patient to swing backwards and forwards between April and November as possible terms for ending the analysis. A graph charting the different terms which she chose in the course of time would have shown the swing of a pendulum stopping on every month between April and November and coming finally to rest somewhere in the middle. What it meant for the patient was to express her desire to be a woman—that is to leave the analysis—and to have a woman, that is the mother-analyst, love her, i.e. to stay in analysis. She needed to try out, in terms of staying and leaving, whether I would accept her even if she wanted to leave me, whether I would allow her to remain in analysis even if she wanted to compete with me as a woman. Her hesitation about setting the time was indicative of her anxiety. Every change of date was interpreted in terms of anxiety and resistance. In doing so the patient was allowed to control the amount of anxiety which she was able to work through instead of being exposed to an overwhelming anxiety which might have been brought on by my setting a date. Setting a date in her mind had the meaning of the analyst 'kicking her out', of closing the door on her as her mother had done. She constantly expected and provoked my doing so, which was interpreted. Ending the analysis was perhaps the most important part of the analysis in this case. The patient was allowed to wean herself on a self-demand system, one might say, instead of being exposed to a repetition of the trauma of rejection. This may be of particular importance in her case, which was in part one of reactive alcoholism. She used to react to frustration and rejection with reactivation of oral-dependent needs. By being given as much time as she wanted, she learned to tolerate separation anxiety without having to regress to the oral fixation point. Perhaps a self-demand system in weaning away from analysis should be considered in cases with oral-dependent needs, particularly with alcoholics.

This change between leaving and staying in the analysis, which expressed the patient's transference feelings in terms of loving and hating the analyst, was also significant in regard to her accepting and rejecting the feminine rôle in identification with the analyst. What Grotjahn (6) has described as going on between candidate and training analyst was not very different in this patient. She carefully sifted out what she liked and disliked about me first on a transference level, then on a reality level, and chose what she felt she wanted to adopt and what was useless for her. Her neurosis was one of 'wrong' identification, namely with men on a phantasy level; her cure corrected her 'wrong' identification by a 'correct' one,

namely with a woman and with accent on reality.

The old rule of setting a date and sticking to it against the resistance of the patient still holds of course in other cases. A patient who had accepted the date which we had discussed and decided upon told me on two consecutive days that we could end the analysis ' right now '. This was interpreted as her resentment against ending the analysis and—in keeping with former material—as a reaction to transference phantasies. When these transference phantasies were discussed, the patient reversed her position entirely, told me she hated to leave, and attempted to prove that she still needed help, and suggested continuing the analysis beyond the date we had set. I was bewildered as to the meaning of this changed attitude. I wondered, as one always does when a patient claims she needs more analysis, whether I might have made a mistake; maybe she did need more. However, she could not produce any of her former symptoms. She seemed to try—called the robber or the anxiety ' with her little finger ', as Anna Freud said—but it did not work. Although she was practically well, there was something she acted out regarding this date. It was this reversal of behaviour which finally gave us the clue. She wanted to avoid knowing when the last session would be. She did not want to say good-bye and did not want to know when I would take on a new patient. The new patient signified for her a new brother and a new husband for me. She had successfully avoided knowing the date of her mother's re-marriage. On the other hand, the fact of the divorce and when it had taken place had been kept from her by her mother. She hated to say good-bye to her father because it meant losing him for good. After this memory was clearly brought into consciousness the patient turned to me in a different way, telling me that she knew many of her feelings were transference feelings, that some of these would probably remain to some degree but that she felt that aside from them there were some real feelings which had nothing to do with the analysis. My response to that was that I thought that was so and that analysts had feelings for their patients too. We parted on that note of mutual acceptance. In this case the last session was significant because only a planned last session faced the patient with the necessity finally of giving up certain transference phantasies and with it facing a reality which she had so far avoided. Although we had discussed and worked through the same material previously, there was that item of ' That's it ' that was missing in it. It was the living out of an experience which up to that point had remained unclear, the correction of unfocused feelings and thinking, which the last session brought into focus. With the analysis of this last material the patient and I considered the analysis finished. She then made the remark which I reported, discriminating between real feelings towards me and a residue of transference feelings. Perhaps I may elaborate on this idea somewhat. It is a problem which has been discussed by Silverberg (10). He discriminates there between transference feelings and reality-based feelings, be they positive or negative, but he also points out that this is true also for the analyst in his feelings of counter-transference and his reality-based feelings.

In the process of analysis we are constantly working with the healthy part of the patient's ego, allying ourselves with it and gradually strengthening it. Gradually that part becomes more prominent and re-establishes its control over the unconscious; therefore, beginning from the time when the analyst and the patient decide to end the analysis, unconscious content is reviewed, worked through, missing material may fall into place, but comparatively little new material appears. Perhaps we should consider a great deal of new material appearing in this phase as an indication that the analytic process is still continuing and needs to continue, that the patient is not ready to end. If unconscious material does diminish in this time, we find that we deal increasingly with the conscious part of the ego. We discuss the neurosis, the sickness with the patient as we would with a third person. We share each other's opinions on his neurosis. As the patient diminishes his need to transfer his feeling and old relationships on to the analyst, his observations of him become keener. The patient attempts to look at the analyst realistically. In talking with the patient on a reality level, evaluating his neurosis, his progress, his remaining weaknesses, discussing his plans, the analysis offers more than a ' blank surface ' as it has previously done and helps the patient to establish a real relationship aside from and above the remaining transference relationship. We do in general credit patients with a great deal of unconscious understanding of the analyst's personality, which goes on side by side with transference feelings. It seems to me in keeping with the analytic process, through

which unconscious material becomes conscious, that such unconscious understanding of the analyst should become conscious too, even though a residue of transference may remain.

One of the most common difficulties which patients have in leaving the analysis is the idea that they will never again see the analyst. This is known as one of the reactions symbolizing birth and death (Rank). For some patients the idea of birth is the prevalent one with dreams expressing the birth process, drowning, boats pulling away from their moorings, doors which are forced open, narrow passages through which the dreamer has to squeeze, etc. The parting also has the meaning of death, particularly for those patients whose neurosis is significantly connected with somebody's death. In spite of analysing all the ramifications of this trauma, in material and transference some of these patients cannot get over the idea that the analyst is going to die when they are separated from him. Every separation, be it over a week-end or during a longer vacation, is connected with this anxiety. These patients particularly need the assurance that they are allowed and expected to keep a certain contact with the analyst by calling occasionally, visiting or writing. This anxiety came particularly to my attention on the two occasions I moved to other cities during my work with patients. It was then that some of them went through a great deal of anxiety which was a repetition of their feelings at a person's death. A patient whose neurosis became manifest with her mother's death, after having corresponded, telephoned me from New York to Seattle obviously to hear my voice; and that was the last I heard of her. In these cases the analysis does not end with the last hour on the couch; the fact that the analyst continues to live in spite of the patient's fears and death-wishes for him has to be proved after the last hour. It is in line with these considerations that we often find it extremely difficult to continue or resume an analysis with a patient after the death of a previous analyst.

There are other cases, too, and for other reasons, where some relationship with the patient has to be continued after the end of the analysis. In working with candidates in training or in doing a second analysis with colleagues, contacts after the end of the analysis are usual. Although this possibility has been discussed and analysed in connection with material and transference, there is a varying amount of apprehension in their contact with the analyst. I consider it a sign of successful analysis if the former patient feels at ease and can ' take or leave ' the analyst. But it seems to me, particularly in a small group with frequent contacts, that it takes about a year after the end of the analysis for the patient to reach a certain equilibrium with the analyst. This process is described by Annie Reich (9) as follows: ' The students have the opportunity to see their analysts in the frame of reality, and the magic omnipotent features of the relationship collapse more readily under these conditions and may be replaced by a mature friendship or a working relationship. The final solution of these last traces of transference can be considered as a final growing up of the patient.' The acceptance of the former student-patient is a necessary step. I cannot conceive of therapeutic results continuing firmly when the analyst rejects the former student-patient after the end of the analysis. Even after the analysis the analyst continues to be a transference figure; that transference may recede, but there will always be a residue of it which may serve as a stimulus to further emotional health or neurosis.

What we observe in colleagues is in no way different with other patients. It has been my experience particularly with children, who would say, ' I want to see you at least once in a while. You are too valuable a friend to lose.' I would of course always assure them that I would remain their friend, sometimes adding: ' You can come whenever you want to see me, and you don't need to throw a temper tantrum, steal, vomit or whatever the symptom was in order to do so.' It is interesting to note that none of my little patients has ever misused this permission and made a nuisance of himself. I have adopted the same procedure with adult patients with the same results. They come occasionally, but never misuse the privilege. From a technical point of view I think that such a procedure removes the traumatic effects of ending an analysis in an active way. The analyst himself refuses to let it be the threatening and sadistic ' never more '. The ' mourning reactions ' (Annie Reich) can be reduced to a certain extent. If ' seeing the analyst in the frame of reality ' helps candidates to resolve the transference, and if residues of transference are considered potential material for sickness, we should pay more attention to this particular problem with other patients also, and to keep the door open for a patient to return for a visit

may serve this purpose. It also proves to the patient that the analyst is not afraid of personal contacts, which has been frequently one of the patient's problems. Frequently symptoms or an anxiety attack reappear when termination of analysis is discussed with the patient. With these symptoms the patient makes a last attempt to hold on to the analyst. Yet this is only of secondary importance, like the secondary gain in a neurosis. The repetition of the initial symptom is the beginning of the repetition of the whole neurosis compressed into a short period of time. It is as if the patient wanted to make sure that he can control his neurosis, that he can control the forces of his unconscious. We are reminded of the words used by the sorcerer in Goethe's *Zauberlehrling* (The Sorcerer's Apprentice—Music by Dukas), ' In die Ecke, Besen, Besen—Sei's gewesen! ' Only in a successful analysis it is not the sorcerer who uses the magic words, but the apprentice who has learned the magic words from him.

SUMMARY

(1) The timing of the end and how to bring it about is a procedure which needs to be co-ordinated with the needs of the patient, and therefore will be different in every case. If we hold ourselves too strictly to rules of ending, we are apt to act out rather in our own behalf instead of understanding the meaning of this termination for the patient and to help him in understanding and working it through. (2) We may, through our own behaviour, help the patient to dissolve the transference or to continue it to a large degree after the analysis by overlooking our own counter-transference. The counter-transference is truly the counter part of the transference, because it is through our counter-transference that we keep a transference alive in the patient longer than need be. In doing so we prevent the patient from increasing his reality-testing abilities; a residue of phantasies around the analyst is encouraged to remain undisturbed, and this may become ' potential material ' for future sickness. To resolve the counter-transference becomes a major part of the analytic process of termination. (3) The termination of the analysis is an important phase of therapy. It is like the finale in a musical movement which repeats the leading motives of the piece.

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SHORT COMMUNICATIONS

A NOTE ON THE ENDING OF AN ANALYSIS [1]

By MARION MILNER, London

Although there is perhaps no such thing as a completed analysis, most patients do, sooner or later, stop coming to analysis. Perhaps we, as analysts, are handicapped in knowing all about what ending feels like, for by the mere fact of becoming analysts we have succeeded in by-passing an experience which our patients have to go through. We have chosen to identify ourselves with our analyst's profession and to act out that identification—a thing which our patients on the whole are not able to do. But we have to manage as best we can; and here is an attempt to describe what no longer coming to analysis meant to one particular patient.

This ending was not something which happened as a logical result of the patient's being considered cured; in fact, the ending preceded the cure by many months, for it was not until the analysis had actually stopped that the symptom began to move at all.

The patient, an unmarried woman of thirty-three, had had a headache since the age of thirteen. When she was sent to me, the diagnosis had been hysteria with a hypochondriacal under-layer. Her own description of the headache was that it was like a black cloud or fog that separated her from everything and penetrated into her brain, making her utterly incapable.

She had had three years' analysis with another member of the Society, and was approaching the end of her second year with me when the question of termination was raised. She maintained persistently that the headache was no better, that she was utterly bored in her work, and could never hope for a better job as she was untrained; also that the money available for her analysis had almost run out. All this was true, with the further difficulty that I had too many low-fee patients at that time to be able to carry on at a merely nominal charge. Moreover, I did not feel justified in encouraging her to continue, in view of the results so far obtained after five years' work. We therefore mutually agreed that the analysis could be looked upon only as a failure, so far as the symptom was concerned, and had better stop.

One characteristic of the analysis during the two years with me had been the patient's complete detachment. Although she had brought plenty of significant material and described extreme emotional states, she always kept me entirely out of the picture and her conscious attitude remained oblivious of all transference interpretations. During the two months or so after the decision to stop but before actually stopping she told me: (*a*) that she had never let analysis influence her; (*b*) that she had had no belief in it anyway; (*c*) that she would not know what she thought of me until I chucked her out. Then we stopped. I knew, of course, that it was a risk, but I felt it was a risk that had to be taken. I told her also that I was not going to fill up all her hours at once. Two of them, which had been in the late evening, I intended to keep free, so that she could telephone if she ever wanted to come.

She came five times in the following six months. Eight weeks after the last of these visits I had a letter saying she was getting married. She added that analysis alone had made this possible and that she was deeply grateful. A year later I heard through a friend that she had never been so happy in her life, and was successfully adjusting to all the conditions of married life, which, in her case, included step-children and frequently a house full of guests. Two years later she herself wrote to me to say how happy she was. There was no mention of the headache.

The first of the five visits occurred two months after the official ending of the analysis. Among other things, she said:

[1] Read at a Symposium on the Termination of Psycho-Analytical Treatment at the meeting of the British Psycho-Analytical Society, March 2, 1949.

She has been feeling utterly ghastly, a burning sort of pain weighing her down, down the whole of her front, a terrific weight on her chest. . . .

Dream, can't get it out of her mind.

In some sort of colossal prison hall full of people.

Next to her was an old grey woman with wispy hair.

She and the woman were tied down by guards with sort of tent ropes reaching to the floor.

A young man is brought in, and defies the guards.

She decides to try too, though with no belief that she *can* free herself; but she finds the pegs give way and she goes off with the ropes clattering round her neck.

She runs down frightful passages . . . and suddenly begins to feel she is racing down and down into the black depths of her own soul.

She reports utter rage and fury against me for not finding her a decent job or curing her headache.

The old woman was directly associated with her mother.

The second visit, again after a two months' gap, contained definitely admitted hope. The third, after a six weeks' gap, brought an admission that the headache did vary in virulence. The fourth, a week later, brought a dream-phantasy that left the headache ' different '.

In phantasy she saw herself as a little child, lying in glorious sunshine, utterly relaxed, like a cat by the fire.

Then mother had appeared, like a thundercloud, and fiercely punished her.

She'd called out ' Why! Why! Why! ' and her cry had echoed through the mountains.

Afterwards she had felt utterly in disgrace, everyone against her.

But for several days since, the headache has been less overwhelming—just a headache.

At the fifth and last visit, another week later, she reported for the first time enjoying lovely spring sun, and also admitted, indirectly and for the first time, to having sexual wishes.

Obviously many things can be said about this material and the conditions under which it appeared. The point I want to make at the moment is the effect of the stopping on the relation to the mother, as lived out in the transference. Her first analyst's comment to me had been that he felt the mother ' had really been a bitch '. But in analysis, all my attempts to help the patient to see how fiercely she was denying this fact had been quite fruitless. She seemed to be forced to feel herself completely on her mother's side in every way, just as she had tried to keep herself completely on mine. And this had led to great conflicts, because the mother had certainly been pegged down all round on the subject of sexuality. So apparently (though this of course is a great over-simplification of what happened) the break with me, felt by her as a ' chucking out ', did enable her to risk having a separate existence and therefore separate standards and a morality of her own. Thus the dream-phantasy of intense sensual enjoyment, with its passionate cry of ' Why! Why! ' to the mother's prohibitions, did represent her first taking responsibility for her own sexuality, as shown also in the next session when she admitted it to me.

Certainly such material as this is commonplace in psycho-analytic experience. But what is of interest is that it all happened after the official ending; also that before the ending there was nothing classical about the analysis, in the sense that what looked like appropriate interpretations did not seem to have any effect. It was almost as if the analysis had been done while the patient herself was not there—and the headache had remained immovable. But her first reported dream after stopping contains the image of racing down into a black pit and away from the pegged-down mother. Certainly it is possible to look on this image as borrowing some of its significance, if not from actual memories of the physical experience of being born, at least from the symbolic idea of birth. Also the utter sense of helplessness that the headache produced, combined with choking and strangling sensations fitted in with this idea. Apparently the analysis could not begin to ' take ' until after she had lived through this psychic experience of being born; also she felt that she could not be ' born ' except by leaving analysis. It looks, too, as if, when she did get herself born, the work done in analysis, which apparently had had no effect, began to take effect retrospectively.

Obviously this was not an ideal way to end an analysis. On looking back I can see that it might have been possible to avoid such an ending if I had understood more clearly why the interpretations, although based on evidence in the material, were not causing changes in the symptom. If I had understood more about how far this patient had not yet taken the risk of feeling herself a separate person in a world of separate people, and how the capacity to take this risk develops, the course of the analysis might have been different and the ending perhaps different also.

As it was, the ending and its sequel were, I think, determined by the fact that the patient's mother, although according to family tradition adored by all, was often really bad, in the sense that she stultified the child's development. So it was not until the patient had felt that I had been really bad to her, by ' chucking her out ', and at the same time I had taken the responsibility for it, that she had become able to recognize her hate of her mother, and so become free enough to begin life as a separate person with standards of her own. The question why it is so necessary for some patients to find that their analysts really are what the patients, in the transference situation, believe them to be, is beyond the scope of this paper.

THREE PSYCHOLOGICAL CRITERIA FOR THE TERMINATION OF TREATMENT[1]

By W. HOFFER, London

To formulate criteria for the termination of treatment is far from an easy task. Simplification has to be avoided, in spite of the demands of beginners. What has been said about termination in the past may be disappointing, but cannot be disregarded. One cannot learn from the mistakes of others if one overlooks them. It needs a collective effort, for which this generation of psycho-analysts probably is not yet prepared, and the awareness that we are not out for dicta but in search of the principles which determine our actions.

About ten years ago the members of this Society were asked: 'What are your criteria for termination? symptomatic, psycho-sexual, social? are your criteria mostly intuitive?' One-third, that is eight out of twenty-four psycho-analysts failed to answer the question at all, and a majority admitted that their criteria were essentially intuitive (Glover and Brierley, 1940, p. 111).

What do I think are the criteria for the termination of treatment? My answer would be this:

In comparison with other psychotherapeutic methods, psycho-analysis is not characterized by a certain number of sessions per week, or by the duration over a number of years, or by the arrangements in the consulting room, but by the fact that it initiates, lends aid to and utilizes certain mental processes, which were for the first time studied and described by Freud.

These mental processes take effect during the whole of the analytic procedure and play their part when termination is in the analyst's mind.

Firstly: Psycho-analysis aims at bringing consciousness and the unconscious nearer together. This is achieved by means of free associations and interpretations. Here we have one of the oldest and most valid criteria for termination of treatment: the degree of awareness of unconscious mental processes.

Secondly: Were it not that the structure of the mind is more complicated than the division between consciousness and the unconscious implies the patient would first acquire the art of interpretation, then apply it to the derivatives of his unconscious conflicts and strivings, and finally control tensions by translating them into the language of consciousness. In fact, this procedure is still the sole aim of certain methods of psychotherapy derived from early psycho-analytic teaching (abreaction through speech).

In psycho-analysis more than this happens: resistances have to be spotted and interpreted. Less repression, and less resistance against the repressed, results in an increase of preconscious and perceptual mental activity. The countercathexis which, before removal of repression and resistance, has guarded the unconscious resistances is now partly invested in the transference situation, partly used in the mental activities outside the transference situation from which the patient had so far been debarred. Counter-transference plays its rôle in the manner in which these energies are channelled during the analytic process.

Thirdly: Apart from making the unconscious conscious and removing resistances, the change from acting out into *remembering in the transference situation* is the third important aspect of the analytic process, in which both patient and therapist are involved. The aim is to limit the scope of the transference neurosis by widening the knowledge of the patient's past and reducing the necessity to repeat in the present.

Within the transference neurosis the length of treatment and its termination have to be viewed from two angles: the scope of the transference neurosis in width and depth and the analyst's skill in dealing with it.

Why not turn to other aspects when searching for criteria for termination?

We are as yet far from being in a position to describe all the mental processes which take place in the analytic situation, and we cannot say how they become involved in the analytic process. As you know, for instance, telepathic

[1] Contribution to a Symposium on 'Criteria for the termination of psycho-analytic treatment' held by the British Psycho-Analytical Society on March 2, 1949.

transference processes have been suggested or described by Freud, Burlingham, Eisenbund, Gillespie and others. What we have tacitly agreed upon is to call a procedure analytic which takes into account the difference between conscious and unconscious, the existence of resistances and the transference phenomena. On these, I think, we have to focus our interest when discussing termination of treatment.

The symptoms are the signposts for the understanding of the patient's mental machinery; his psychosexual and social relations, his failures and achievements, the pleasure he enjoys and the anxiety and guilt he suffers are merely results or accompaniments of the functioning of his mental apparatus. In the analytic situation we are actively dealing with processes in this apparatus and with functions of inner perception leading to awareness.

The criteria for the analytic process itself and for its termination should therefore be *psychological*. The process itself, we know, is conditioned by various factors which we cannot change as we will.

Sometimes it has been made a reproach against analysis that the patient knew everything but no change took place in his behaviour or mental activities. I think this is one of the many points where individual factors enter the picture of psycho-analytic practice, e.g. the analyst's range of knowledge of mental mechanisms.

What is the fate of the transference neurosis in relation to termination of treatment?

Once it was thought that the transference neurosis becomes dissolved during treatment (by interpretation and working through) and this leads to termination. The flame, it was thought, dies owing to lack of fuel. We now assume that this can hardly ever happen. The transference neurosis is not a reactive, but an active manifestation; it is not created by reality but by the spontaneous pressure of the Id.

The infantile object relationships become intensified in the transference neurosis and remain there at first unrecognized. If the subsequent emergence of a transference neurosis is not interfered with by too brisk transference interpretations, symptomatic-neurotic suffering changes into feelings of inferiority and of mental pain due to frustrated infantile love (transference neurosis proper). Interpretations lead to the transformation of these transference feelings and actions into memories. Mental energy, invested in the repressed and disguised infantile object relations, is thus at first drained into the transference situation and then into memories of those relations, a process which has been much clarified by James Strachey. The painful actuality in the transference situation becomes transformed into memories of the past, and with it the patient's actual infantile relation towards his analyst will gradually become past as well and will relieve him from much actual suffering.

This, however, can happen only if the patient identifies himself with the analyst in his analytic activity. It shows itself in the patient's ability to interpret for himself the derivatives of his unconscious, to spot and to remove resistances, and finally to understand and within limits to control the acting out within the social setting.

This is an Ego activity which has been acquired during the course of analytic treatment, which has been learned by the patient without being taught. It may go on after termination of the actual analysis, or after this has been restricted in frequency, time and aim.

This learning process is closely related to what has been called the substitution of the patient's infantile super-ego by the analyst's super-ego. I think it not advantageous to call it a substitution. It is a change in the patient's ego due to *identification*; it affects of course the ego-ideal and therefore the super-ego, but the mechanism involved is identification within the ego with the *functions* of the analyst. Emerging out of the transference neurosis it is another *psychological criterion* for termination of treatment.

The scope of this identification is restricted by the small number of functions an analyst has to fulfil in an analysis. To say it as simply as possible: it is the identification with the analyst's skill in interpretation, in analysing resistances and transforming acting out into memories of infantile conflict and trauma through the medium of transference acutely experienced and interpreted.

Individual analysis is the study of individual histories. History can never be exhausted, but its study does not always need two people. Treatment can be terminated when the analytic process can hopefully be entrusted to the apprentice himself. Provision for help if necessary has of course to be made.

There are patients who do not fit into this picture, and for them psychological criteria either do not exist or have to be looked for elsewhere.

ON THE TERMINATION OF ANALYSIS[1]

By MICHAEL BALINT, London

I

The criteria for termination can be classified under many possible headings. From among these I have chosen three, not only because they appear to me important, but mainly because I have studied them more closely than the others. The first heading is that of *instinctual aims*. That means a firmly established genital primacy, the capacity to enjoy full genital satisfaction, i.e. mature genitality. I wish to point out that I mean more than a simple sum-total of all the component sexual instincts; mature genitality is in my opinion a new function emerging about puberty, possibly as the result of a ' natural process ' such as I tried to describe in ' Eros and Aphrodite '.[2]

The second group of criteria can be summed up under the heading: *relation to instinctual objects*. I dealt with this topic in a recent paper: ' On Genital Love '.[3] The gist of my thesis is that genital love is definitely *not* a natural, spontaneous process but an artefact—the result of civilization (or of education)—a complex fusion of genital satisfaction and pre-genital tenderness; its psychological expression is genital identification with the object based on an exacting reality testing, and its aim the changing of an indifferent or even reluctant object into a loving and co-operating genital partner.

The third group of criteria can be summed up under the heading: *structure of the ego*. The ego must be strong enough to cope with tensions caused—*inter alia*—by: (*a*) the use of alloplastic instead of autoplastic methods for dealing with reality; (*b*) the acceptance of unpleasant ideas; (*c*) the sudden increase of excitement before and during an orgasm; (*d*) maintaining the genital identification with the partner even in phases of temporary dissatisfaction; etc. Obviously the common basis of all these functions is reliable reality testing which enables the individual to maintain an uninterrupted contact with reality even under strain.

I am aware that all this is well known. In the same way we know that these are rather perfectionist standards, which nobody can fulfil completely. A sceptical critic would be more than justified in asking at this point: Granted all these criteria, how much deviation from these high standards should be allowed before finishing a cure? As this question cannot easily be answered, I propose to try another approach.

II

As the attempt to establish theoretical standards did not prove promising, we shall drop the search for external criteria and try to describe clinically what actually happens when an analysis terminates. In two of my papers [4] I have tried to describe this process which I called *new beginning*. Briefly what happens is: the patient gradually gives up his suspicious attitude towards the world of objects, especially his analyst; parallel with this a particular kind of object relation emerges which could be called archaic, primitive, or passive, object love; its main features are the unconditional expectation of being loved without being under the obligation to give anything in return, and of obtaining safely and without fail the desired gratification, irrespective of the interests of the object; an important point is that these gratifications demanded with vehemence never go beyond the level of forepleasure. Naturally these wishes can never be fully met in the framework of the analytical situation, but—according to my experience—they must be fully understood and also met to a considerable degree. For only if

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[1] Contribution to a symposium on the Termination of Psycho-Analytical Treatment at the meeting of British Psycho-Analytical Society, on March 2, 1949.

[2] *Int. J. Psycho-Anal.*, **19**, 199–213, 1938.

[3] *Int. J. Psycho-Anal.*, **29**, 34–40, 1948.

[4] ' Charakteranalyse und Neubeginn ', *Intern. Zeitschrift für Ps.A.*, **20**, 54, 65, 1934. ' The Final Goal of Psycho-Analytical Treatment ', *Int. J. Psycho-Anal.*, **17**, 206–216, 1936.

the analyst has succeeded in leading his patient through all these Scyllas and Charybdises can the patient develop from this newly begun primitive passive object love to mature genital love. This development goes parallel to, and depends largely on, the patient's gradual allowing of more and more rights to his objects, i.e. by developing his capacity for testing the reality with regard to his objects and in this way endeavouring to arrive at an acceptable compromise between his and his objects' demands.

If this process can develop in an undisturbed way a surprisingly uniform experience dominates the very last period of the treatment. The patient feels that he is going through a kind of re-birth into a new life, that he has arrived at the end of a dark tunnel, that he sees light again after a long journey, that he has been given a new life, he experiences a sense of great freedom as if a heavy burden had dropped from him, etc. It is a deeply moving experience; the general atmosphere is of taking leave for ever of something very dear, very precious—with all the corresponding grief and mourning—but this sincere and deeply felt grief is mitigated by the feeling of security, originating from the newly-won possibilities for real happiness. Usually the patient leaves after the last session happy but with tears in his eyes and,—I think I may admit—the analyst is in a very similar mood.

It is very important that we should not be led astray by the obvious symbolism of this description, although naturally we must remain fully aware of all the implications. But I think the real problem is much deeper than the symbolic expression, and the symbolism is only a clumsy language in which this deeper problem is expressed haltingly and rather incompletely.

This deeper problem, which I regard as the crux of our discussion, can be formulated in several ways, all of which try to convey the same content. I shall discuss only two such formulations.

The first asks the question: Is the analytical cure a ' natural ' or an ' artificial ' process? i.e. does the analyst's task consist only of removing the obstacles created by the individual and social traumata—after which the ' natural ' processes will take charge of the cure?

(*a*) If the answer is Yes, we may expect rather uniform happenings in the end phase; moreover these events will probably be expressed in some general symbolic form, such as that of giving up an intra-uterine existence which retrospectively will be described as both good and bad; or (*b*) If the answer is No, we must expect widely varying experiences in the end phase, dependent on—among other factors—the degree of the overall maturity reached, on the problems that happen to be the last ones to be dealt with, on the personality of the analyst, etc.

Another formulation—using more general concepts—may ask: (1) Is *health* a natural state of equilibrium? i.e. do processes exist in the mind which—if unhampered and undisturbed—would lead the development towards that equilibrium? or (2) Is *health* the result of a lucky chance, a rare or even an improbable event, the reason being that its conditions are so stringent and so numerous that the chances are very heavily weighted against it?

The two dilemmas are essentially identical. There are a few other possible formulations, but we need not trouble ourselves about them on this occasion. Analysts have not as yet been able to give a satisfactory answer to these questions. Roughly there are two camps. It is interesting to note that those who think that mature genitality is not simply a chance sum-total of a motley mixture of component sexual instincts but a function *per se*, also think that health is a ' natural ' equilibrium and the termination of a psycho-analytic cure is a ' natural ' process. And there is the other camp which maintains fairly unanimously that health, the termination of an analysis and mature genitality are similarly the result of the interplay of so many forces, tendencies and influences that one is not justified in assuming governing ' natural ' processes.

III

Obviously the answer to this important dilemma lies with the clinical experiences, i.e. with the study of truly terminated analyses. Unfortunately the available material is very meagre and unconvincing. Still, it is worth while to examine it. The first source is my own experience. This cannot be really decisive because (*a*) it is subjectively coloured and (*b*) my numbers are too small. Taking all those of my cases which went beyond the trial period, I could observe the end phase as described in this paper roughly in two cases out of ten. A very poor proportion indeed. Still I remain convinced that in the main my description is correct. My principal reason is that in every case in which we failed to achieve a proper

termination, I think I know what went wrong, although I must admit that once the mistake was made and the phase of new beginning was spoilt, it was hardly possible to remedy the situation. In such cases the analysis usually ended in a state of partial success, seldom of dissatisfaction or even of resentment, in spite of sincere goodwill and honest efforts from both sides. The reassuring point is that very often the processes started by the cure developed further after the so-called termination, and in this way the final results have often become quite commendable—still a feeling of having missed something seems to persist for long periods with the patient as well as with his analyst. Obviously this is not very convincing material.

Control analyses should provide a second source of material. Unfortunately control work as a rule finishes before the analyses can be carried out to their termination: a very unsatisfactory state of affairs both for the candidate and the supervisor—and not least for the patient. Apart from the real difficulties, an additional reason for our tolerating this grave fault in our training system is the unconscious and unformulated doubt mentioned above as to the possibility of any ' natural ' termination of analysis.

The last source of material should be found in other analysts' cases. Unfortunately, we know so little about our colleagues' techniques and we are so secretive about our own that only a very small fraction of all cases can be used by an outsider. The small fraction about which an outsider may know something is the training analyses.

For several reasons one would expect fewer complications here than with neurotics; unfortunately the very opposite is the case. It is generally known—though not officially recognized—that quite a number of candidates continue their analyses without any break after qualification. This entails not only a short period for some tidying up, but honest all-out treatments. I think this fact, which I believe occurs in every Training Institution, is of crucial importance to our topic.

Our present training system is based on the empirical fundamental rule that no one shall analyse who has not been analysed himself. Obviously this must mean more than just having started analysis or having had say a few dozen sessions. Although the rule does not say it in so many words, one is led to assume that it implies that the candidate should finish his own analysis before being allowed to treat patients without any further compulsory supervision.

Apparently this is not the case, and we are working with two standards instead of one. Standard A, less stringent but publicly controlled and strictly enforced by our Societies and their officers, says that the candidate is healthy (i.e. trained) enough for starting to analyse patients on his own, for being qualified as a fully-fledged analyst, but as yet not necessarily healthy enough to deal with his own neurotic unconscious problems. Standard B, more stringent but uncontrolled by our Societies and their officers, a matter of private agreement between the patient (a fully qualified analyst) and his training analyst, determines the criteria of the real termination. We know a good deal about Standard A, but unfortunately hardly anything about Standard B.

I wish to add that this dual standard system is a comparatively new development away from—what may have been—too perfectionist an idea, a kind of coming-down-to-sober-reality policy. Some of the factors of this development which started, as far as I know, in the thirties, are known; they include, among others, incompletely finished analyses of several of our colleagues, which later necessitated a resumption of their analyses as a private venture, inefficient selection of the candidates at the start, the ever-lengthening duration of the normal training analyses which in turn always leads to heavy external pressure, especially of a financial nature, etc. It would be a very important piece of research to find out more about the conscious *and* unconscious motives of this latest development in our training system.

As things are at present this source of clinical material does not yield a reliable answer to our problems either. Obviously standard A is useless to us; and of standard B we know as little as of any other terminated analysis.

IV

To sum up: we have excellent theoretical criteria to decide whether an analysis has been properly terminated or not. Unfortunately we must admit that they are rather perfectionist standards, and we are not able to define what would constitute an admissible deviation from our criteria. I am well aware of the fact that other analysts prefer to use criteria partly or wholly different from mine. The above criti-

cism, however, remains true for any set of criteria.

On the practical side, when examining the end phases of my truly terminated analyses, we landed in the dilemma: is health a ' natural ' state or is it only the result of extremely good luck, a very rare event? And we had to admit our inability to solve it.

And lastly, when looking for reliable clinical material the study of which might enable us to formulate an empirical, or at least a statistical, answer to our problem, we found that such material—even if it exists—is inaccessible to any other analyst, i.e. is available only to the analyst who actually conducted the analysis to its end. As, for the time being, there is no possibility of control or verification, all statements about truly terminated analyses are, of necessity, subjectively coloured and therefore not absolutely reliable.

This is, of course, as true of my own statements as it is of those of anyone else taking part in this discussion, until such time as reliable material is made accessible to all of us for proper criticism. As long as things remain as they are now, any contribution to this problem must run the risk of bringing but little to the solution of this problem, and of disclosing a good deal about the personality of the contributor, albeit in a highly sublimated form. I hasten to say that this holds good for this contribution too.

Still, in spite of this uncertainty, every year several analyses are terminated. Even if we take the cautious view that each member of our International Association who is a practising analyst finishes only one or two of his cases per year, the sum-total will be 1,000–2,000 per annum. Using my figures quoted in this paper, according to which at least two out of ten finished cases are truly terminated, we arrive at the figure of 200–400 per annum. This is a vast material indeed. I write these notes in the hope that they will stimulate some colleague to collect this material critically and to use it as a means of finding a real answer to our problems.

ON THE CRITERIA FOR THE TERMINATION OF AN ANALYSIS [1]

By JOHN RICKMAN, London

The lack of a systematic follow-up of our cases several years after treatment is ended makes difficult an accurate assessment of the criteria for termination. We know something of the cases which come back for more analysis and the reasons for the incompleteness of the first therapy, but we do not usually know enough about those who do not come back, though we sometimes get favourable accounts of those whose analysis was terminated before we, at the time, thought advisable.

There is a second reason for hesitation in defining the criteria. The class of case now treated, speaking generally, is more of the character analysis type than the simpler hysteria and obsessional with which psycho-analytical work in the main began. Both our frontiers and our method of work are changing, and also our criteria.

In an analysis two parties have to be satisfied, the patient and the therapist. The patient is often satisfied too early with the results obtained in the procedure, while the therapist has his own and less subjective criteria. One of these can be given a sort of code name, ' Irreversibility '; i.e. the process of improvement in personality-integration and adaptability, which has been reached thus far, should be of such a degree and kind that, even without further analytical aid, there will be no reverse process or regression on the cessation of treatment—granted of course that no enormous stress is put upon the patient after treatment ends. The matter can be viewed in another way, viz. has the treatment removed the major obstacles to the action of the integrative processes which operate within every living organism, so that these integrative processes will in the end get the upper hand without further analytical aid?

Such general considerations I believe to be fundamental to our topic this evening. When looking more closely at specific criteria, we can single out a few of undoubted importance:

(*a*) the capacity to move smoothly in memory (and to let old feelings surge up on occasion) from the past to the present and back again, i.e. the removal of infantile amnesia, which of course includes a facing and working through of the Œdipus complex,

(*b*) the capacity for heterosexual genital satisfaction,

(*c*) the capacity to tolerate libidinal frustration and privation without regressive defences, and without anxiety,

(*d*) the capacity to work and to endure unemployment,

(*e*) the capacity to tolerate the aggressive impulses in the self and others without losing object love in its full sense and without guilt, and

(*f*) the capacity to mourn.

These are listed in the order, I believe, in which these criteria have appeared in our periodic literature.

These various factors, though subject to quantitative change, are combined by the clinician to form a pattern of action which is or should be assessed, not in respect to an ideal personality, but to one which will not disintegrate or regress under instinctual pressures or privations. The point I want to stress here is that the ultimate criterion (singular) is a *pattern* combining many factors each of which may have quantitative variations and each of which has a ' point of irreversibility '.

Thus far I have not spoken of transference phenomena. I will come to them in more detail later; we know these phenomena are the source of our greatest insight into the depths of the patient's mind and at times are also a source of confusion as to the way in which he is actually shaping in the external world. This last is for several reasons:

(i) because of the thoroughness with which the ego is oriented in analysis to the working

[1] A Contribution to a Symposium of like title given at a meeting of the British Psycho-Analytical Society on April 6, 1949.

through of the unsolved emotional problems of infancy,

(ii) because of a self-punishing tendency not to appear to the analyst to be ' good ' when the patient feels himself to be evil,

(iii) because of a wish to cling to the analyst and so perpetuate an infantile situation and to keep future patients from the couch.

For quite a variety of reasons the analyst is presented with the disintegrative aspects of the patient and often less clearly with the integrative ones, for which reason it has been remarked that ' Psycho-pathology says more about what is yet to be done than what has been done, because a large part of what has been done is a silent process of integration which is also carried on in the unconscious but is manifest when the occasion calls for it in the external world.'

Now to come to a point mentioned earlier. The week-end break, because it is an event repeated throughout the analysis, which is also punctuated by the longer holiday breaks, can be used by the analyst when making the integrative pattern before referred to in order to assess the development of the patient.

The patient, who early in our work pictures his analyst spending the week-end with nose deeply buried in books and never stirring save to go to a library to get still more books, later in the analysis pictures him going to the theatre and eventually enjoying family life.

The patient who, on the contrary, pictured her analyst as spending even week-ends in America in pursuit of a wife or lover, eventually pictured him in domesticity in London.

The week-end and holiday interruptions of the work forced up transference phantasies; as the work continued these changed in character in correspondence with the internal pattern of forces and object relations within the patient. The point of irreversibility could be given when, despite upheavals in the patients' lives, the picture of the analyst's week-end remained a balanced one and included the sixfold capacity I have mentioned.

Some patients react with dread to the coming week-end break so that after Wednesday they dare not ' let themselves go ' because they cannot bear the great wrench of leaving on the Friday. Every week-end to such patients is a bereavement. But as the analysis proceeds it becomes first a sadness, then a relinquishment, and finally the analyst moves freely in and out of their life space. Where is the point of irreversibility? I know of no fixed and definite criterion, but when there can be sadness, no matter how poignant, without the gestalt of the analyst changing in the patient's mind, then I think it can be said that that point has been reached.

I do not want to go into more detail about the week-end response but to refer again to a previous formulation: the ultimate criterion is a *pattern* combining many factors each of which may have quantitative variations and each of which has a ' point of irreversibility '. The clinician is a person who has to match the pattern of ' the patient as a whole ' against the pattern of normality which might be described in terms of self-adjusting equilibria. It is further suggested that the criteria for terminating should be considered in relation to the criteria for beginning the particular treatment of the particular patient. The presenting symptoms, which should be kept in mind throughout the analysis, in nearly all cases are the result of a long defensive process and therefore are a guide, though not a complete guide, to the structure of the personality, no matter what other symptoms develop or what other psycho-pathological phenomena are disclosed during the course of the analysis. In this final and most clinical—I would not deny the use of the word clinical-intuitive—assessment the removal of the roots of the initial symptom complex (not its suppression) is of outstanding importance.

CRITERIA FOR THE TERMINATION OF ANALYSIS [1]

By H. BRIDGER, London

The analytical situation can be considered as a transitional community of two people created for the purpose of changing and reintegrating the patient's internal object relationships, and thus progressively enabling him to bridge the gap between one way of life and another. On the time scale of the patient's external world, this transitional community exists for fifty minutes on a certain number of days each week. Between one session and the next there may be periods of one or more days, as well as an occasional break of some weeks or months. These periods are either arbitrarily decided upon by the analyst or patient, or are mutually arranged. In any case they are all occasions when the patient has an opportunity to experience for himself the implications of terminating analysis.

It should be remembered, however, that terminating the existence of the transitional community in the patient's social life is dynamically different from terminating the psychoanalytic process. The former is an event in the external world; the latter is the end-result of a developmental internal process.

The criteria being sought are therefore those which will enable the analyst to determine, and before that even to predict, relative to the various external forces operating on analyst and patient, the optimal moment in time when the event of termination should occur in the psychoanalytical process.

Defining the nature of a transference interpretation, James Strachey (1) wrote: ' I have suggested that it is a procedure which enables the patient, under controlled conditions and in limited doses, to employ his sense of reality for the purpose of making a comparison between his archaic and imaginary objects and his actual and real ones; and I have argued that the small-scale correction which he can thus make in his attitude towards the external world is the first step towards the internal readjustment which is our ultimate aim.'

On this basis, at any particular moment in time during the analysis, the integrate of small-scale corrections made in the patient's attitude to the external world should have a correspondence with the integrate of steps made in the internal readjustment. The forces operating on the patient in the external world can be assessed only in the light of the material brought by the patient in all its varied forms. Actual evidence from other sources concerning the changes which the patient is able to make in his external relationships with the various social groups to which he belongs are not normally available to the analyst.

It was possible, however, for criteria to be established within this wider social frame of reference by those working in other kinds of transitional communities where the therapeutic techniques were different not only from psychoanalysis but from each other. I refer to the follow-up study of patients from an E.M.S.[2] Hospital by Guttman and Thomas (2), and to the follow-up study by Curle and Trist (3) of those repatriated prisoners of war who had voluntarily attended Civil Resettlement Units before returning to civilian life. The latter case in particular is of special interest, since these social scientists were able to establish criteria for the rehabilitation and reintegration of people into social communities. These criteria formed the basis for an assessment of the success of treatment experienced in a carefully designed resettlement process. In addition, the criteria provided a framework not only for the reconsideration of the structure and culture of the units in relation to their purpose, but also for evaluating the degree to which a repatriate was ready to terminate his stay at the transitional community.

In the psycho-analytic process the infantile

[1] Read before the British Psycho-Analytical Society, as one of Four Short Communications on the Criteria for the Termination of an Analysis, on April 6, 1949.

[2] Emergency Medical Service.

patterns of behaviour and unresolved emotional conflicts, which are determining the patient's course of action, are brought to light and worked through in the transference. Nevertheless, the integrate of the internal and external reconnections thus made requires the consideration of various frames of reference if criteria for the final termination event are to be found. One way of looking at the problem would be to consider the criteria for ending an analytic session, since the fact that fifty minutes has elapsed cannot be considered to be the sole criterion. I shall, however, confine myself to two sets of situations which might provide the analyst, in the analytical situation, with similar opportunities to those which the social scientists mentioned above have found in their transitional communities. The first set is comprised of the short-term experiments in termination which the patient experiences throughout analysis by being set the task of getting along on his own between one session and the next. In contrast, the second set comprises those experiences in the patient's external world which involve the termination of relationships, for example, change of job, place of residence, divorce, death and so on. In both sets, consideration has to be given to the forces at work, and the circumstances prevailing, at the time of the separation events.

In the former case the analyst is continually receiving communications, in one way or another, from the patient, indicative of the degree to which his internal world is coping with the anticipated break periods, or has coped with the actual experience of them. For the patient's internal world the time scales of these breaks are by no means the same as the time scale of the external world. In the ' here and now ' of the analytical situation the coming, or past, break of a day, week or month may well mean, or have meant, ' for ever ' on the patient's internal time scale. One aspect therefore of this set of situations might be the assessment of the patient's ability to tolerate the operation of a reality time scale in his internal world. Another aspect concerns the main ways in which separation events occur, namely, whether the breaks are determined by the analyst, by the patient, or are mutually agreed upon. There would be qualitative and quantitative differences in the assessment of them when compared one with another. Considering these and other aspects the analyst could, on the specific knowledge gained in the context of the analytical situation, construct what one might call periodic ' progress reports ' on the patient's preparedness for the termination event.

As and when, in the second set of situations, the patient brings into the analysis material concerning those separation events occurring in his external world, whether in advance, at the time, or in retrospect, it is worked through in the transference. In this frame of reference another series of ' progress reports ' could be made.

Although part of the therapeutic task of the analyst in this transitional community of two people is always the examination and assessment of the patient's ability to cope with many other problems relating to the final termination event, particular emphasis has been given here to separation experiences and short-term experiments in termination, which occur throughout analysis, and are dealt with in the analytical situation. In constructing, on this evidence, specific periodic ' progress reports ' for each patient, and comparing them one with another throughout analysis, certain general criteria for the final termination event may well emerge.

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ON THE CRITERIA FOR THE TERMINATION OF AN ANALYSIS [1]

By MELANIE KLEIN

The termination of an analysis revives the anxieties and depressive feelings experienced in earlier situations of parting, ultimately going back to the emotions which arose in babyhood at the time of weaning. At that stage, as my work has shown me, depressive anxiety reaches a climax. The loss of the primary good object, the breast, reinforces the depressive anxiety lest the introjected good object—the mother's breast and the mother—should have been destroyed by aggressive impulses and greed. This anxiety arises out of the greater capacity of the ego to synthesize love and hatred in relation to the object, and therefore the infant feels that his loved object is endangered. This is the essence of those anxieties (and ensuing defences), which I described as the infantile depressive position. Normally, the infant copes with his feelings of mourning and guilt in various ways, among which the testing of reality is of great significance. He overcomes his persecutory and depressive anxieties in relation to the loss of his internalized and external good objects as his relations to external reality and to people develop; for these processes underlie the testing of reality described by Freud as an important part of the work of mourning. The anxieties and defences experienced in babyhood are revived when the analysis is coming to an end.

My criterion for the termination of an analysis is, therefore, as follows: have persecutory and depressive anxieties been sufficiently reduced in the course of the analysis, and has the patient's relation to the external world been sufficiently strengthened to enable him to deal satisfactorily with the situation of mourning arising at this point? By analysing as fully as possible both the negative and the positive transference, persecutory and depressive anxieties are diminished and the patient becomes increasingly able to synthesize the contrasting aspects of the primary objects, and the feelings towards them, thus establishing a more realistic and secure attitude to the internal and the external world. If these processes have been sufficiently experienced in the transference situation both the idealization of the analyst and the feelings of being persecuted by him are diminished; the patient can then cope more successfully with the feelings of loss caused by the termination of the analysis and with that part of the work of mourning which he has to carry out by himself after the end of the analysis.

There are well-known criteria for terminating a psycho-analytic treatment such as hetero-sexual potency and the capacity for love, object relations and work. All these criteria are inter-related with the new criterion which I have just suggested, for every step in development and, accordingly, progress in the course of the analysis are bound up with the diminution of persecutory and depressive anxieties.

[1] Read before the British Psycho-Analytical Society as one of Four Short Contributions on the Criteria for the Termination of Psycho-Analytical Treatment, April 6, 1949.

SHORT COMMUNICATION ON CRITERIA FOR TERMINATING ANALYSIS[1]

By SYLVIA PAYNE

The criteria for the termination of psycho-analytical treatment are usually drawn up on the assumption that there is one pattern of human psychological development at which it is best to aim. It is not possible when the case of an individual is considered to take a fixed model as the ideal to be aimed at, because of the variety of factors connected with the environment both present and past which may be unalterable.

In spite of this fact the criteria put forward in general terms, such as the psycho-sexual development to be attained, the ability to have good social relationships and the disappearance of symptoms, must always be considered together with the actual possibility of the attainment of complete mental health.

We should be in a much better position to state the criteria for the termination of an analysis if we carried out some research on the subject by recording at the beginning of the treatment a prognosis for subsequent comparison with the final result.

The main facts to be noted would be:

(1) The initial diagnosis.

(2) The age at which manifest symptoms appeared, and the duration of the illness. The history of childhood development if obtainable without questioning.

(3) In character cases, the presence or absence of recurring failures or successes of the same type. This observation aids the assessment of the part played by neurotic formations in the character.

(4) The nature of environmental influences, whether unusually unfavourable or good. In addition, the likelihood of the immediate environment being changed for the benefit of the patient.

None of these factors can be estimated with any accuracy until some analysis has been carried through, but some observations made at the first interview and corroborated later are valuable.

As to the actual experience which a patient may go through at the termination of the treatment: theoretically he has to transfer libido from a relationship to the analyst which at different times has been that of a suckling-mother relationship, a child-mother or -father relationship, a brother or sister relationship, an alter-ego relationship, or a relationship with an idealized figure comparable to those produced by projection on to a school master or mistress in adolescence, etc. These transference relationships have all been uncovered and analysed, but may still leave traces of dependency, varying with the severity of the illness. The problem is how far the patient has attained ego independence as the result of integration.

Many analysts have pointed out that a recrudescence of symptoms sometimes occurs when the patient knows the end is near.

I have found the end compared with the anxieties of growing up, leaving school, leaving the university, rebirth, weaning, the end of mourning, all being critical times involving a re-organization of ego and libidinal interests. When a breakdown in mental or physical health has occurred in the past at critical times the analyst knows that there is ego instability, and a dependency which will make the termination of the analysis difficult.

In each case we consider the patient's degree of libidinal and ego development and how aggression has been dealt with before deciding whether the treatment has done as much as possible. If the decision taken is that further changes are not likely, a way of enabling the patient to face separation must be found. In a few cases it may be best to fix the time of termination; in other cases it is advisable gradually to diminish the number of visits in the week; in a third class the patient may be allowed to make the final decision.

[1] Read before the British Psycho-Analytical Society as one of Four Short Contributions on the Criteria for the Termination of an Analysis, April 6, 1949.

ABSTRACTS

Edith Buxbaum. ' The Rôle of a Second Language in the Formation of Ego and Superego.' *The Psychoanalytic Quarterly*, 1949, Vol. XVIII, No. 3, p. 279.

The histories of two children who clung to a marked accent in speech revealed their hostile identification with their fathers. These fathers had foreign accents. Even though the therapist had an accent herself, the patients' accent disappeared with the resolution of their anxiety. Two adult women are reported who used the avoidance of their childhood language as a mechanism of defence against infantile sexuality. It is demonstrated by the author that learning to speak and enunciate a foreign language is subject to the mechanisms which produce slips of the tongue, stammering and stuttering, and may be employed as a defence mechanism.

Sylvan Keiser.

Ralph R. Greenson. ' The Psychology of Apathy.' *The Psychoanalytic Quarterly*, 1949, Vol. XVIII, p. 290.

Apathy is defined as a state of affectlessness, and its striking characteristic is the visible lack of emotion and drive. It was studied in men who had spent three or more years as prisoners of war in the hands of the Japanese or who had been stationed for years on isolated islands in the Pacific. Apathy was the end-result of prolonged deprivation. The earlier reaction of rebellion led to defeat and humiliation until finally all response seemed to disappear. There was loss of hope with an impoverishment of thinking processes. The regression went to a passive, oral, libidinal level as well as a severe restriction of ego functioning. In contrast to the depressive patient, the apathetic individual had an external object which he hated freely and without quiet. Improvement began when lost objects were again charged with libidinal cathexis.

Sylvan Keiser.

Otto Fenichel. ' The Symbolic Equation: Girl = Phallus.' *The Psychoanalytic Quarterly*, 1949, Vol. XVIII, p. 303.

An earlier article dealing with a transvestite is reviewed and the formulation is as follows: patient in woman's clothes = mother with a penis = penis in general. The longing to be admired as a girl required him to equip this girl with a penis and to fantasy her as a penis. Thus ' I am a girl ' and ' my whole body is a penis ' was condensed into ' I = my whole body; a girl = the little one = the penis. Thus the equation ' penis = child ' can also assume the form of ' penis = girl '.

Women who fantasy their body as a penis disprove their oral-sadistic tendencies against the penis through their harmonious unity with it. The history is given of such a woman whose fantasy of being a woman showed its repression of the idea ' I am robbing a man and must therefore fear him '. This idea is applied to several characters from literature, such as King Lear's daughter Cordelia. Mignon is also subjected to investigation from this point of view.

The clown, dwarf and prodigy are all discussed from the standpoint that phallic exhibition is repressed and must be replaced by pregenital exhibition with its fantasies of omnipotence. ' If my penis is too small, I am in my whole person a penis which you must still respect'. This is illustrated by clinical material. The castration denial is twofold: ' I keep my penis by acting as though I were a girl ' and ' girls are no different from myself '. A masochistic patient's tears ultimately related to the poor child being caressed until it wetted itself. The love the man directs towards a phallus girl is passive, phallic and urethral.

In conclusion, the author states that the phallus girl is not only a penis but also a child, fæces and milk. The penis is the final member of the series of introjects and one which is again projected.

Sylvan Keiser.

Ludwig Jekels and Edmund Bergler. ' Transference and Love.' *The Psychoanalytic Quarterly*, 1949, Vol. XVIII, p. 325.

The purpose of the paper is to investigate further and to seek for psychological motives which may explain Freud's statement that the ego employs object cathexis in order to avoid an increased damming up of libido in the ego. The authors discuss the wish to be loved, and state that spatial separation as an expression of anxiety is based fundamentally upon the feeling of the threat to narcissistic unity. The ego-ideal is regarded as a zone for which Eros and Thanatos battle. One root for the ego-ideal derives from the ego's ability to project the aggression on to objects. These feared objects are incorporated into the ego and become the subject of one's own narcissism. The second root of the ego-ideal is the ego's seeking to recover the early perfection that was wrested from it. The ego-ideal is suggested as being that displaceable neutral energy which Freud postulated as being capable of joining with either an erotic or destructive impulse. The ego-ideal stems from narcissistic reserves of the libido and is desexualized Eros.

In love the ego-ideal is projected on to the object and is reintrojected. Thus Eros becomes pre-

eminent, since it has taken over the energy of the ego-ideal. The conclusion arrived at is that love is an attempt at recapturing narcissistic unity, the complete wholeness of the personality which the ego considers as endangered by the daimon, by guilt feelings which disturb narcissistic unity.

In transference the physician unites *via* projection the superego, ego-ideal and daimon. In negative transference the hatred is directed against the physician and the ego. In positive transference the patient wants to be loved by the ego-ideal. In love only the ego-ideal is projected; in transference both ego-ideal and daimon are projected.

Sylvan Keiser.

Bertram D. Lewin. 'Mania and Sleep.' *The Psychoanalytic Quarterly*, 1949, Vol. XVIII, p. 419.

Case material is taken from the history of a young lady who had four hypomanic attacks during her analysis. Each was preceded by a blank dream. Before each episode she had lunch and had gone shopping with a mother figure. In the analytic hour she had a blissful mood of erotic absorption. That night she had an orgasm with a blank dream. She awoke with a hypomania. In her clear periods she had dreams in which young men in bed with her turned into her mother. During the hypomania men played a great part, but her mother was taboo as a topic for analysis.

The blank herald dream is to be interpreted not only as a dream of oral satisfaction of fusion with the mother at the breast, but also as picturing most lucidly the fulfilment of the wish to sleep. The patient's hypomanic attacks were like manifest dreams which denied the latent dream thoughts of the day's residual. Features of the manic are compared to mechanisms that are found in dreams. The elated mood of the manic and his happy dreams were long ago shown to hide death wishes or thoughts of one's death. The dreams of romping and playing resemble the innocent games of the hypomanic. Dreams with endless details are compared to the variety of content found in a typical flight of ideas. After discussing varieties of sleep and wakefulness and dreams, mania may be compared to sleep if the kind of sleep is specified.

Both sleep and mania are the result of an intrapsychic fusion with the breast at nursing, but stupor alone reproduces the infant's sound sleep. Elation repeats the wish-fulfilling dreaming sleep of an older child. This special sleep-equivalent is guarded by a censorship that is created to employ the defence mechanism of denial—of insight—and to prevent emotional acceptance.

Sylvan Keiser.

Siegfried Bernfeld. 'Freud's Scientific Beginnings.' *The American Imago*, Vol. 6, No. 3, pp. 163–196.

This paper is a consideration of the early years of Freud's scientific life, from 1873, when he began his medical studies, to 1885, three years after he went into practice. Although as a boy Freud had had fantasies of having power over men, at seventeen these gave way to a deep interest in the mysteries of the natural world: he decided to study biology. In Brücke's laboratory Freud made a good study of the Reissner cells in the spinal cord of the fish *Petromyzon*, pointing out their relationship to the dorsal spinal roots and indicating their evolutionary position in the vertebrate scale by remarking the mixture of unipolar and bipolar processes. An obscure paragraph in an early paper shows that he foresaw the neurone theory.

Freud did some work in the laboratories of Claus in 1876 and of Stricker in 1885. He deprecated his work under Claus, and his work on cocaine with Stricker was a failure. The writer suggests that Freud could not work under Claus because the latter was the same age as Freud's half-brother, the target of Freud's hostility, while Brücke was the same age as Freud's father, towards whom Freud had arrived at an attitude of love. Brücke, the beloved father, assigned Freud anatomical tasks and reserved the more aggressive and brutal observations of the higher wisdom of physiology for himself. Later, when Freud worked in Stricker's laboratory, he was already severely inhibited in the direction of physiology. He also did some good work in developing new histological staining methods and in translation, both unaggressive from the standpoint of physiological research.

Sidney Tarachow.

Gregory Zilboorg, M.D. 'Clinical Variants of Moral Values.' *American J. of Psychiatry*, **106**, 10, April, 1950, pp. 744–47.

Not all sense of guilt is neurotic, and not to feel guilty is not necessarily a sign of normality. The psychiatrist is not concerned primarily with moral problems, but he does not reject them and he cannot and does not function without moral values. Analysts want to relieve their patients of the sense of guilt for things they have never really or wittingly done, but they leave their patients with a conscious sense of guilt for things they have really done.

Martin Grotjahn, M.D.

A Postgraduate Psychoanalytic Training Program: Its Evolution, Principles and Operation at the New York Medical College. By Alexander Gralnick, M.D. With a discussion remark by Franz Alexander, *American J. of Psychiatry*, **106**, 11, May, 1950, pp. 841–844.

This paper is a brief outline of the present tendency in America to combine psycho-analytic training with the teaching in medical schools. According to the author the difficulties of psychoanalysis are partly due to the fact that instruction is conducted in private institutes rather than in medical schools 'free of dogmatic teaching'. An attempt at such a programme of graduate courses in psycho-

analysis has been made at the New York Medical College. Changes in psycho-analytic ideas must be accompanied by changes in educational forms and methods. Originally there was an urgent need for unaffiliated training, but this time is now gone by.

Alexander describes 'a cultural lag' in the development of psycho-analytic teaching. Psycho-analytic training had of necessity to develop in isolation from the rest of the medical programme, but the plan described by Gralnick is a good example of the gradual liquidation of the 'cultural lag'. In 1948, in Chicago, the Associated Psychiatry Faculties, Inc., was founded. Members of the Association are the psychiatric departments of the University of Chicago, the University of Illinois, Michael Reese Hospital, and the Chicago Psycho-analytic Institute. Its aim is the co-ordination of the general psychiatric and psycho-analytic training of the residents in these institutions, which is a joint responsibility of the Associated Psychiatric Faculties. The resistance of the medical school justifies the isolationism of psycho-analysis, and the isolationism of psycho-analysis vindicates the resistance of the medical schools. With the relaxation of uncritical rejection, the defenders of new ideas can become more self-critical, and tolerate differences of opinion among themselves without which no development in the field of science is possible.

Martin Grotjahn, M.D.

British Medical Bulletin. London. Vol. 6, Nos. 1 and 2, 1949, 10*s*. No. 3, 1949, 5*s*.

Nos. 1 and 2 (a double number) are devoted to mental health and contain articles on the Mental Hygiene Congress held in London in 1948, four articles on different aspects of the relationship of psychology to psychiatry, and articles on child psychiatry, physical treatments, psychosomatics, senescence, juvenile delinquency, the mentally abnormal criminal, and the relationship of the law to psychiatry. The articles are by authorities in each field and contain very useful bibliographies. Dr. Michael Fordham has written a review of analytical psychology. Dr. Edward Glover has outlined his view of the position of psycho-analysis in Great Britain. Dr. W. Clifford M. Scott contributes an article on the 'Progress of Psycho-Analysis in Great Britain' since the days before World War I. Unfortunately this article was entitled by the Editor of the Bulletin 'The Kleinian View'. The author, although in his other writing he has shown his indebtedness to the work of Melanie Klein, in this article attempted to give an all-round view of the progress of psycho-analysis in Great Britain.

No. 3 contains a description of the Mental Health Services in Great Britain. Post-graduate education is outlined by Professor A. Lewis and undergraduate education by Professor D. R. MacCalman. There are articles on occupational therapy; psychiatric social work; psychiatric nursing; community care; and the special provisions for the education of mental defectives.

The position regarding mental health under the National Health Service Act is outlined by Dr. W. S. Maclay. A useful directory of organizations concerned with mental health is included.

The bibliography of publications in the field of mental health (which concludes the survey) is unfortunately very poor.

W. Clifford M. Scott.

BOOK REVIEWS

Contributions to Psycho-Analysis 1921–1945. By Melanie Klein. (No. 37, The International Psycho-Analytical Library, edited by Ernest Jones, London: 1948, The Hogarth Press and the Institute of Psycho-Analysis. Pp. 416. 21*s.* net.)

In a friendly Introduction to this book, Ernest Jones alludes to the ' commotion ' engendered in the British Psycho-Analytical Society by the work of Melanie Klein. This disturbance resulted from the development of two extreme pro- and anti-groups which according to this Introduction, ' between them vociferously, and therefore easily, restricted the quieter scientific endeavours of cooler members.' These non-partisans, amongst whom the present writer is to be numbered, formed an unorganized ' middle group ' which drew fire from both extremes but continued its unspectacular efforts to view the new work in rational perspective. Ernest Jones himself regards as ' grossly exaggerated ' the charge that Melanie Klein's work is incompatible with Freud's, though he would not regard such incompatibility as decisive if experience supported her conclusions, since the further development of psycho-analysis necessitates advance beyond the limits set by Freud himself. Ernest Jones summarizes and comments on some of the more striking of Melanie Klein's contributions, namely:—

(*a*) The development of the play-technique of child-analysis which enabled her to confirm Freud's inferences about the unconscious life of the child and pursue these further, concluding, for instance, that

(*b*) Cannibalistic and other sadistic phantasies, which had been traced to the age of three, ' occur during the so-called cannibalistic stage of infancy itself, which after all seems what one would have expected! '

(*c*) The rôle of introjection and projection in early infancy and the consequent extension of the theory of ' internal objects ', which have had ' important results both for our understanding of the early development and for our daily therapeutic practice.'

(*d*) The appreciation of the resemblances between infantile and psychotic processes and consequent naming of various phases of infantile development as ' paranoid ', ' depressive ', etc.

While cordially supporting Melanie Klein in principle and expecting that many of her conclusions will stand on their own merits, Ernest Jones would not underwrite every one of her present formulations. Indeed, he anticipates some future modifications, e.g. of her acceptance of the Death impulse, about which he himself has serious misgivings. He finds it odd to be criticizing Melanie Klein for too close an adherence to Freud's views, an adherence moreover which is taken in some quarters to be a divergence from Freud!

The book, as its title conveys, includes papers published in various journals between 1921 and 1945. Thirteen of these appeared before the publication of *The Psycho-Analysis of Children* (1932) and contain first statements of views subsequently elaborated in that volume. Readers familiar with *The Psycho-Analysis of Children* may be tempted to skip these earlier papers, but they afford both a guide to the serial development of Melanie Klein's thought as a whole and examples of the germination, growth and establishment of specific ideas. Thus the concept of ' reparation ', foreshadowed earlier, acquires full definition in the 1929 paper entitled ' Infantile Anxiety-Situations Reflected in a Work of Art, etc.' (p. 227). Thereafter, ' reparation ' takes its permanent place in Melanie Klein's formulations and the validity of the concept is henceforth taken for granted. Readers unfamiliar with *The Psycho-Analysis of Children* would find the early papers an excellent introduction to that book.

The early papers (together with *The Psycho-Analysis of Children*) cover what has come to be known as the first phase of Melanie Klein's work, arising out of the use of her play-technique in the analysis of young children. She early concluded that anxiety springs from aggression and that a phase of maximal sadism occurs in early infancy (roughly corresponding to the later oral and early anal primacies of Freud and Abraham). The phantasied attacks on the mother's body, which belong to this phase, give rise to typical anxieties, e.g. the feminine fear of injuries to the inside of the body. Œdipal impulses are also held to appear early, weaning deprivation instigating a transference from nipple to penis and tending to produce in both sexes prolific phantasies of oral intercourse between parents and typical masculine fears of the father's penis within the mother's body. Introjection and projection are said to alternate as dominant mechanisms of defence in early infancy, super-ego differentiation beginning with the first object introjection.

The later papers in the book, particularly the last three, describe the more recent, so-called second, phase of Melanie Klein's work, here published for the first time in book form. The resemblance between certain infantile and psychotic conditions led Melanie Klein to a closer study of their inter-relationships. In 1935 she published ' A Contribution to the Psychogenesis of Manic-Depressive States ' (p. 282). In this paper she posited a genetic connection between paranoia, depression and mania

and ascribed their differentiation to changes in object-relationship, related to developmental changes in the ego. In paranoia, the relatively uncoordinated ego is still chiefly concerned with self-protection against persecutory part-or-organ-objects, readily identified with fæces. With increasing co-ordination of the ego, identification of the self with 'good' objects becomes possible and, from now on, 'preservation of the good object is regarded as synonymous with the survival of the ego' (p. 284). Co-ordination of the ego is accompanied by the transition from part to whole object-relationship, i.e. the object becomes a whole person and no longer an important organ or part of a person. Depressive feelings of loss of the good object as a whole now become possible and a variety of anxieties concerning its preservation or destruction ensue. Phantasies that the good object is in pieces which cannot be put together again are typical of the suggested 'depressive position', as are convictions of dead or dying internalized objects. Dread of the dangers to the self and the good objects may lead to 'manic defence', i.e. to the omnipotent denial of the importance both of the objects and of the risks to which these are exposed, together with paradoxical, hyperactive efforts to master and control all objects.

Depressive anxieties may also initiate restitutive drives; the infant now strives to restore the damaged object and to make reparation for the harm it feels has been done by its hostile and sadistic impulses. More definitely obsessional mechanisms may also be brought into play. Basically, the normal or abnormal outcome of the depressive phase depends on whether or not secure identification of the ego with good internalized objects is effected. The depressive position occurs as early as the fourth or fifth month of life, and, in this 1935 paper, is held to be the central position in development, a cross-roads from which diverging paths lead to various types of abnormality and to normality.

In normal mourning (see p. 311, 'Mourning and its Relation to Manic-Depressive States', 1940) the infantile depressive position is reanimated but is gradually surmounted by identificatory reinstatement of the good parents and the recently lost external object.

From 1936 onwards Melanie Klein's views became increasingly controversial issues. The last paper in the book, 'The Œdipus Complex in the Light of Early Anxieties' (p. 339) is both a re-statement of her main views and an attempt to come to terms with some of her critics. She herself writes of it (p. 399), 'I have two main objectives in presenting this paper. I intend to single out some typical early anxiety situations and show their connection with the Œdipus complex. Since these anxieties and defences are part of the infantile depressive position as I see it, I hope to throw some light on the relation between the depressive position and libidinal development. My second purpose is to compare my conclusions about the Œdipus complex with Freud's views on that subject.' The pursuit of the second purpose has provided a very useful summary of what Melanie Klein herself considers to be her main differences from Freud (pp. 386–390). Apropos of the 'depressive position' she writes (p. 380): 'In the two preceding papers I have repeatedly referred to the infantile depressive position as the central position in early development. I would now rather suggest the following formulation: the core of infantile depressive feelings, i.e. the child's fear of the loss of his loved objects, as a consequence of his hatred and aggression, enters into his object relations and Œdipus complex from the beginning.'

The book closes with a Bibliography, a list of patients referred to in the text and a comprehensive Index.

A summary of all the discussions that have centred on the work of Melanie Klein would fill a book; a review can touch only briefly on a few of the main topics of controversy. Argument naturally tended to focus on those views which seemed to differ most markedly from, or even to contradict, the views of Freud. Thus the contrast between Melanie Klein's description of object-relations and phantasy life in early infancy and Freud's view of this period as auto-erotic and objectless led to many charges of improbable 'precocity' in infantile development according to Klein. However, all hypotheses regarding the earliest phases of infantile experience are, and must remain, highly speculative, depending as they do on adult interpretation of infantile behaviour and inference from later experience. There is also the further point that pre-verbal experience is bound to be falsified to some extent by description in words. It would appear that there is some justice in the contention that Melanie Klein's 'clinical evidence' has been drawn chiefly from the use of the play technique with children from about two and a half years of age and upwards. Many psycho-analysts would agree that the oral 'game' played by a two or three-year-old may be a genuine revival of suckling or weaning experience, but many would also argue that the form of the 'game' corresponds to the child's current development rather than to the age from which its content seems to derive. Melanie Klein's descriptions of infancy often give the impression that she 'retrojects' (Bibring) into early phases a degree of mental organization that belongs to the later stage at which the early experience is revived, e.g. in play. But the conclusions drawn by child-psychologists from their observations of infants suggest that the pace of development in the first six months is rapid. If, as they agree, an infant of three months can recognize faces, the 'familiar faces' must have acquired some degree of objective definition, though this may be purely sensory-affective and need involve no high degree of mental organization.

In elevating a ' depressive position ' to the central point of development Melanie Klein has been said to have ousted the Œdipus complex from its priority in pathogenesis and to have attributed far too great formative influence to what amounts to a secondary Unconscious or ' enclave ' of depressive phantasies. As mentioned earlier, ' The Œdipus Complex in the Light of Early Anxieties ' (p. 339) is in part an attempt to meet some of these criticisms. Readers will decide for themselves how far this attempt succeeds, e.g. how far a ' core of depressive feelings ' is more satisfactory than a ' depressive position '. It will be evident, however, that depressive phantasies need not necessarily form an ' enclave '. Their economic fate, like that of any other phantasies, will depend upon the degree to which they become synthesized with the developing ego-organization or dissociated from it. All dissociated phantasy-systems are liable to become pathogenic ' enclaves '.

Far more serious is the charge that Melanie Klein's conception of development is too exclusively progressive and that she has greatly underestimated the rôle of regression in pathogenesis, e.g. in the ætiology of manic-depressive states. In fairness it must be said that in the Œdipus paper (p. 339) she pays more attention to regression and to such related processes as idealization than she does in her earlier work. But her specialized interest in depression tends to give an effect of regarding all human beings as variants of a manic-depressive type. It should be self-evident that the child's experience prior to its culmination in the late or classical Œdipus phase necessarily influences the development, nature and mode of dealing with that phase, but it is a fact of clinical experience that the phantasies of adult manic-depressives often bear hall-marks of attempted regressive solution of Œdipal situations. Hence, while Melanie Klein may rightly be considered to have enlarged our understanding of the symptomatology of manic-depressive states and indeed of animistic experience in general, including the sphere of ' values ' and religious experience, it must be admitted that her ætiology is more open to question.

In the reviewer's opinion, it is important that two sets of considerations should be borne in mind in any attempt to assess the validity of Melanie Klein's work, in whole or in part. In the first place, it is a mistake to regard her views as forming an independent system, an alternative or substitute for psycho-analysis. Her work should be regarded as a contribution to psycho-analysis whose validity is still in process of assessment. It tends to be forgotten that the foundations upon which she built, e.g. the mechanisms of introjection and projection, the occurrence of identification with introjected objects (melancholia), and the existence of pregenital mental organization (primacies), were all recognized before Melanie Klein began her work. This work is in many respects a super-structure on these foundations, an expansion of work already begun by Freud and Abraham. Lop-sidedness in the super-structure or imbalance in the new elaboration are capable of correction in the light of further knowledge and experience. But agreement with or difference from Freud cannot be used as a criterion of validity in itself without stultifying the development of psycho-analysis and depriving it of any claim to be a science, i.e. a body of modifiable hypotheses, not an unalterable creed. Melanie Klein's errors tend to be errors of over- and under-emphasis, over-simplification and too ready generalization. They are the kind of error always liable to accompany pioneering in clinical and technical fields by minds attuned to personal feeling and experience rather than to the logical (and terminological) niceties of metapsychology. So far from creating any new metapsychology, it will probably be found that any contribution of Melanie Klein's which proves to be of lasting value can be readily translated into the terms of current metapsychology.

The other set of considerations refers to the time factor. Clinical testing requires time. But a certain passage of time is also needed to establish the psychological distance or detachment favourable to just assessment. As is often the case in other sciences, it is not the scientific problems which are insoluble, rather is it the human equations with which they are linked that are intractable. Many of the present generation of psycho-analysts in this country are still too closely involved in the human situation to be able always to use to best advantage their judgment about the scientific position. If the present semi-federal arrangements continue to keep the British Society together as a whole, later generations may well look back to the present day and wonder what all the fuss was about. It is equally likely that these generations will themselves be concerned with newer controversial issues and awkward personal equations of their own.

Marjorie Brierley.

Male and Female: A Study of the Sexes in a Changing World. By Margaret Mead. (New York: Wm. Morrow and Co. London: Victor Gollancz: 1950. Price 18*s.*)

The aim of this book is to pass on the ' insight ' of the anthropologist to those who are not acquainted with the work of scientific anthropology. Its purpose is more than informative; it is propagandist in the best sense of the word. The author, committed to the belief that more knowledge means more freedom, attempts to convey her knowledge of the rôle which ' maleness and femaleness ' play in cultural processes to a broad audience. She firmly believes that such knowledge, integrated in the ' mind of the nation ', will eventually influence society to make the best use of the specific endowments of both sexes, and thus help mankind in ' rising to heights of which each living generation can only glimpse the next step of the ascent '.

The book is divided into four parts. The first

outlines the tremendous scope of the work and introduces the methodology of anthropology under an inaccurate title: ' How an Anthropologist Writes '. The author describes vividly the lures and challenges, the discomforts and hardships of collecting observations in the field. But she omits to write about the reservoir of concepts which the anthropologist takes with him in the field to direct his observations; she does not orientate the reader in the theories which underlie the analysis and organization of his material. Probably she assumed that theories would unduly burden a work intended for a popular audience. In the reviewer's opinion, however, such a presentation would have added clarity to the discussion and would have diminished the persuasiveness of her style. She offers extensive references to sources and literature, but these are helpful only for those who know the concepts.

Many of the concepts on which the author draws freely in the interpretation of her material did not exist at the time of her field studies. Intuitive observer as she is, she brought back a store of impressions which she could interpret again and again in the light of the newer concepts of psychoanalysis. The interplay between anthropological observations and psycho-analytic concepts, implicit on every page, makes the book, especially Parts II and III, stimulating reading for the psycho-analyst.

In Part II, the author introduces her ' cast ', the seven South Sea peoples whom she studied for many years: the Samoans, the Manus of the Admiralty Islands, the Mountain Arapesh, the cannibal Mundugnor, the Tsbambuli, the Iatmul headhunters and the Balinese. The geography, the economic conditions, the marriage customs and the child-rearing systems of these separate ethnic units reveal the underlying bio-sociological drama of the struggle between the sexes.

It is determined by the ' way of the body ' to grow, to learn, and to fulfil its biological purpose in procreation. No social development can alter the fact that children of both sexes are born and nursed by the mother, and that through nursing they receive impulses of different meaning towards their maturation and sexual function. However disguised, complicated, ' muffled ', the first learnings of the body may be for the children of Western civilizations, psychologically they are identical with those of these seven cultures in which people of both sexes of all sizes and ages, live together, ' slightly closed and simply accepted ', and where the processes of identification—as it seems to the author—are exposed with undeniable directness.

Of the seven cultures, it is in Samoa that the ' two-sex world ' appears to be least troubled by conflicts and denials. There the biological advantage of womanhood seems to be obvious; to grow up to become a woman and a mother seems a shorter and more assured process than the equivalent development of the male. The infant girl receiving the nipple in her mouth develops her receptive tendencies, which will later be integrated with the receptive tendencies of her sexual function. The male child begins life with a similar gratification of the receptive tendencies; he cannot, however, indulge it fully, for he has to learn to overcome his receptive impulses in order to respond more fully to the eliminative impulses of his body. This greater differentiation of the eliminative tendencies leads to a differentiation in male activities; finally, elimination becomes the domineering impulse in the male sexual activity. Man's rôle in procreation is not as perceptible as that of woman. The little girl knows that she merely has to grow up and then she will be like her older sisters, her mother; her body will become large and she will bear children. The little boy cannot be so certain about the ' belonging ' and the function of his penis. Therefore, the envy of the womb, the competition for fulfilment in motherhood is the central emotional experience of men. Although in the other cultures it is not as uncomplicated as it is in the Samoan, the author discovers in all of them the ' womb-envying pattern ' in various disguises. This central conflict dominates the relationship between man and woman and leads finally to the differentiation of masculine and feminine attitudes characteristic of a given culture.

In Part III the author considers not only her seven South Sea peoples, but also draws on general knowledge of human societies in order to demonstrate that society, to survive, must form patterns which come to terms with the differences between the sexes. Actually, these seven South Sea cultures demonstrate seven variations of the psychodynamic and sociological elaborations of the competition between the sexes. This in turn produces seven different shadings of rearing children. Learning, which begins with unconscious identifications communicated from body to body, has to achieve the transformation of primary body experiences into culturally approved elaborations. The culture, determined by the attitudes of man and woman towards each other, develops educational techniques and institutions which perpetuate the same attitudes. These small homogeneous societies develop stable, stylized behaviour patterns for each sex and each age level. Boy and girl grow up to follow the pattern of their parents as husbands, wives and as parents. Their behaviour is highly specific and predictable, as if cast in static moulds. While markedly different as between the seven ethnic groups, the members of these slowly changing cultures show but little individualization within one particular people.

This is the background against which the author contrasts ' The Two Sexes in Contemporary America ' (Part IV). Her aim is to show the manifestations of the ' two-sex world ' in a civilization where, except for the biological facts, everything is changeable. It is in this part of the book that she heaps up her arguments. In a single paragraph,

even in a single sentence, one statement may refer to the biological differences, another to psychological attitudes towards them, in different generations, and, at the same time, indicate different manifestations in school groups, in politics and in sundry other situations. This quick interplay of allusions to information gathered from various fields is impressive; it may be convincing for those who can follow it, but it is confusing for those who are not acquainted with the material, and are unwilling to follow the author's biosociological thesis. Many readers, men especially, will develop resistance to it. Yet the aim of the book is to remind the reader that while in some cultures people believe that women alone hold the secret of life and in others that men alone are its masters, we in our culture should be able to realize that while both sexes participate in creating life, both are responsible for improving it.

Besides this general, culturally significant thesis, the book poses many new problems and offers many new solutions for old ones. For some psychoanalysts, the reversal of the central rôle of the castration complex, as demonstrated here, may be evident on the basis of their psycho-analytic experience; others will doubt the universality of the ' envy of the womb '. In any case, Margaret Mead's interpretation of her material will make a dent in the concept of the biological determination of the female castration complex : penis envy. Most psycho-analysts will agree with and enjoy the author's sensitive illustrations of early body-learning, whether it is described from the point of view of introjection or of projection. For example: ' If the child is to know how to hold a baby in its arms, it has to be held ', or ' If the mother who holds a child in her arms is so conscious that some day it will bite that she meets the sucking vigour of the newborn as if it were biting, very possibly the child may learn about biting before it has any teeth '. In the same way, the author's observations in regard to sphincter control and its possible influence on the integration of the sexual function are interesting. And there are many other observations and conclusions which will stimulate discussion. A significant effect of this book may be that it will instigate research projects which will elaborate some of the problems so keenly observed and ardently presented by its author.

Therese Benedek, M.D. (Chicago).

Œdipus Myth and Complex. By Patrick Mullahy. (New York: Hermitage Press, Inc. Pp. 538. London : Allen & Unwin, 1950. Price 37*s*. 6*d*.)

This book purports to give an account of the theory of the Œdipus Complex as discovered and developed by Freud, and of the most important modifications to his theory made by leading ' psychoanalysts ' since his time. There are four admirably concise and comprehensive chapters setting out the stages by which Freud developed his libido theory and theory of the neuroses, with extensive quotations and references to the main translated works and papers. The theories of Adler, Jung, Rank, Horney, Fromm and Harry Stack Sullivan (of the William Alanson White Psychiatric Foundation, Washington), follow in separate chapters. Finally, the author attempts a critical survey of the seven theories, and the last 150 pages are devoted to a translation of Sophocles' *Œdipus* trilogy.

In the first part of the book there are passing references to Abraham, Hans Sachs and Ernest Jones among the classical analysts, and of the many singular omissions in a bibliography of seven pages, there is no reference to the work of Ferenczi, Anna Freud or Melanie Klein. This is therefore a book about Freud and those who have seceded from his theories, and if this were clearly stated there could be no objection to it. The title is misleading, as the Œdipus complex dwindles visibly *en route* till in the work of Dr. Sullivan it appears merely as a statement that the parent, feeling a sense of strangeness with the child of the opposite sex, tends to treat him with ' kid gloves ', so that in this relative freedom from authoritarian pressure, the child feels greater affection in return.

There is, however, an underlying theme which is not without interest for the psycho-analyst. All six deviators from Freud's findings agree in abandoning the theory of instinct, ' the cumbersome libido theory ', and in playing down the rôle of infantile sexuality, or completely eliminating it as a serious factor in psychological development. They are agreed also that the mother-child relationship is the operative factor in development failure, conceiving the relationship in a wide nurtural sense and not in terms of specific instinctual care. Sociological and environmental influences affecting the child directly or through the parents' methods of education are stressed, education being conceived as influence over the entire pre-adult years. At the same time there is general agreement to abandon the concept of the super-ego as a structured internalization of these influences related to the resolution of the Œdipus complex. Dr. Sullivan's account of the acquisition of social attitudes through empathy in the acquirement of language is the most elaborate and systematized attempt to produce a new dynamic of the process of internalization.

The synthesizing idea behind the selection is clearly set out in the author's critical appraisal of the theories he describes. Mullahy attacks the libido theory as a typically nineteenth-century " mechanistic-materialistic ' concept. It emerges, he says, from a reductive system of analysis finding its explanations of character and personality in an early interplay between biologically conceived instincts in biologically determined phases (e.g. the Œdipus phase), and historical events in the family situation. This interaction, being conceived in quantitative terms, can give no explanation of differences in emotional quality. ' If one assumes that human

nature is to be understood in terms of classical mechanics, of masses in motion or forces acting in certain directions, or of any limited number of physical laws, how can one explain *purpose*, *consciousness*, what we loosely call *will*, not to speak of the *unconscious* which are qualities and modes of experience, not physical entities?' (p. 320).

This is both to condemn a science which is content to achieve working concepts adequate to to observed phenomena, because it is not a philosophy, and to prejudge findings achieved by methods suited to the investigation of unconscious derivatives, because they do not conform to what we should expect from a knowledge of conscious processes. It is like discarding the results of a microscopic analysis because the naked eye sees the picture otherwise.

Moreover, in his search for a philosophic explanation of 'quality' Mullahy very largely overlooks the dynamic explanation inherent in the theory of the defence mechanisms to which Freud returned in 1926, and which was further elaborated in the work of Anna Freud, and forms a cornerstone in the writings of Melanie Klein.

Mullahy's critical criteria are essentially those of verbal and logical consistency in consciousness. He is therefore equally disturbed by the flight from reason of C. J. Jung, and by the frank abandonment of objectivity in favour of illusion in the later work of Rank. He fails to understand why the application of his own criteria in the vast psychological field opened up by the discoveries of Freud can lead only to the untidy and inadequate descriptions of desiccated character types which he finds no less unsatisfactory in the work of Adler, Horney and Fromm.

In assessing concepts which are concerned with unconscious processes, some account of the methodologies used to establish them is a *sine qua non*. The concepts must surely be judged by the adequacy of these methods, and on the range of clinical facts which these concepts can cover satisfactorily for working purposes. In the present instance this might be a Herculean and thankless task, but the fact does not permit us to condone an academic presentation, however useful and extensive, which is critically naive.

Ruth Thomas (London).

Myths of Middle India. By Verrier Elwin. (London: Geoffrey Cumberlege. Oxford University Press. Pp. xvi + 532. Price 25*s*.)

In this book Dr. Elwin has detailed the oral literature of a very vast and complex cultural area, and has combed it with such thoroughness that the result is almost perplexing in its richness of yield. Material from nearly forty-two tribes has been collected, stretching from the Central Provinces to Western Orissa. The book is divided into four parts: Man and His Universe, The Natural World, Human Life and Human Institutions. Each myth or story is carefully related to its tribal setting and the geographical area. The chief merit of the book is, perhaps, in its authentic and lively translation of this oral literature into cold print and a foreign language. The problems surmounted here can hardly be over-estimated, because this oral literature is expressed in languages that are intimately interwoven with the psycho-physical habits, experiences, and peculiarities of these people—as is amply evidenced by the content of their myths. Dr. Elwin has at times preferred to retain the flavour and feel of the original idiom and metaphor even when it has made the translation entirely fantastic.

It is almost impossible to indicate the richness of the material contained: it ranges from the myths and stories about creation and the universe to those explaining tears and laughter. The functions and activities of the human body, the birth and existence of animals, the origin of religious institutions, magic, dance, etc., all are detailed as reflected in the phantasies of these people.

To the readers of this Journal the long chapter on 'Psycho-pathology: the Vagina Dentata Legend' may be of special interest. The section on the Human Body is introduced by Dr. Elwin with a note of caution to the 'fastidious reader' and it is one of the many merits of this book that Dr. Elwin does not flinch on any prudish grounds from detailing his material. As he puts it: 'To the aboriginal—let us be frank—the most important thing about the human body is its sexual apparatus; it is this on which he lavishes his most tender fancies; it is this which excites his most eager interest in narrative'.

Dr. Elwin prefaces his collection of the myths and stories about Vagina Dentata with a well-documented account of those found in other cultures, specially North America. He then gives some forty-six stories from these tribes covering the various aspects of this legend: fear of dangerous penis, fear of pubic hair, fear of the teeth in vagina, fear of faecal smell, etc.

He tries to summarize the various theories advanced to explain these phantasies, and discards the possibility of any explanation in terms of 'physical and medical basis'. He tends to favour the explanations advanced by psycho-analysts in terms of castration fear (Roheim), penis-envy, fear of menstrual blood, etc. He starts with a long quotation from the *British Encyclopædia of Medical Practice*, the name of the author of which is not given. Though he mentions all these theories and explanations he does not advance any personal opinion and leaves it on the vague note of these legends being 'the result of complex psychological situations'.

This is the basic weakness of the book: its lack of methodology and conceptual framework. The material is projected in a vacuum and no indication is given as to its relation to the living experience of the people—their ways of living, eating, their

attitude towards bodily habits, etc. Whenever such material is advanced it is most illuminating. For example, in the Vagina Dentata chapter when we are told that they have ' few pleasures to divert them, they indulge in sexual intercourse far too frequently. Their ordinary lives are deeply marked by fear and anxiety '. And this lack of information is bound to hamper any intensive use of the material collected. As such it will retain a fantastic character. What is urgently needed now is to put these myths and oral traditions in their local frame of reference and native environment. Until then speculation might well run amok with this most tempting material.

Dr. Elwin had set out to give ' an impression of how these people think and live '. He has admirably succeeded in the first but not the second. This failing stands out all the more prominently because in his short introduction on the nature and function of myths he quotes a very pregnant statement from his book *The Baiga*: '. . . the myth breathes life into ancient customs; it make the unintelligible real. . . . The myth makes everything contemporary '. Unfortunately we are given very little account of these everyday activities that are, to use his phrase, vitalized by the myths.

The work is, in spite of these criticisms, a very rich source-book, collected with a genuine sympathy and feel for the material, and would make most rewarding reading.

It is printed in clear style and is supplied with a Motif Index and a General Index—useful for reference purposes.

Masud Khan (London).

Kama-Sutra of Vatsyana (*The Hindoo Art of Love*). Translated and edited by B. M. Basu. Revised by S. L. Ghosh. (Calcutta: Medical Book Co., Fifth Edition, 1944. Pp. 282. R.F. 6.)

Psycho-analysts will be indebted to a member of the Indian Society, Mr. Ghosh, for a revision of Dr. Basu's translation of this Sanskrit work which dates from before the fifth century A.D.

Every-day Psychoanalysis. By G. S. Bose. (Calcutta: Susil Gupta Publishing Co., 1945. Pp. 280. R.F. 6.)

This popular introduction to psycho-analysis by the former President of the Indian Society begins with a general statement regarding modern psychology. It ends with a historical description of psycho-analysis, the psycho-analytic view of normality, the psycho-analytic claims with regard to treatment and an outline biography of Sigmund Freud. In the body of the book the analytic interpretation of choice of work, normal mood variations, childhood development, crime, dreams, marital difficulties in general and sexual difficulties in particular are discussed in a manner suited to those with no previous acquaintance with psychology or psycho-analysis.

W. Clifford M. Scott.

The Interpretation of Dreams. By Sigmund Freud. Translated by A. A. Brill. (London: George Allen and Unwin. Pp. 600. 1950. Price 16*s.*)

In 1900 this classic, which demonstrates, to use Freud's own words, that ' there is a psychological technique which makes it possible to interpret dreams ', was first published. This is the third reprinting of the revised translation based on the eighth German edition first published in English in 1937. The translation of the first German edition was published in Great Britain in 1913.

No review of this book, which is so important both historically and as a present-day text-book, is really possible or necessary. Students of psychiatry who try to begin to learn about dreams without reading it and without keeping it at their bedside will regret the time they have lost when they eventually come to understand that they should have digested its contents before tackling the voluminous literature of the past fifty years which is based on the clinical observations and theoretical formulations given in this book.

What is Psycho-Analysis. By Ernest Jones. (London: George Allen and Unwin. Pp. 126. 1949. Price 7*s.* 6*d.*)

This book was reviewed by William Needles, Vol. 29 (1948), p. 181, at the time the American Edition was published in 1948 by the International Universities Press, New York.

W. Clifford M. Scott.

Studies in Psychosomatic Medicine. An approach to the cause and treatment of vegetative disturbances. By Franz Alexander, M.D., and Thomas Morton French, M.D. (New York: The Ronald Press Company, 1948. Pp. 568.)

This is a collection of previously published papers and is based largely upon the psycho-analytic study of patients suffering from chronic disturbances of the vegetative organs. The term psychosomatic is used as a methodological concept which aims at studying and treating simultaneously psychological and somatic factors in their mutual interrelation. It is repeatedly stressed that there is an intimate affinity between certain emotional constellations (nuclear conflicts) and somatic responses, i.e. etiologic specificity. The vegetative neuroses are distinguished sharply from hysterical conversions; in the former the somatic symptoms are not substitute expressions of repressed emotions, but are normal physiological accompaniments of the emotion. It is only the chronicity of the emotional ension which leads in the latter to a morbid state. Thus in a gastric neurosis the repressed need to be taken care of—to be nursed—leads to certain vegetative responses manifested by secretory and motor changes.

The need to postulate and consider additional factors besides the specific emotional constellation is constantly in sight. Thus it is claimed that the same infantile need to receive when frustrated leads

to excessive mobilization of glucose from the glycogen stores of the body, resulting in the clinical picture of diabetes.

The basic hypothesis of specific etiologic emotional constellations often leads to subtle points of differentiation. Thus the asthmatic attack is considered a reaction to the danger of separation from the mother or loss of her love. However, urticaria results from ' last-minute frustration ' of love longings. To distinguish and contrast urticaria from asthma the authors (Saul and Bernstein) are forced to the following subtle reasoning: ' the wishes for love (in urticaria) are less regressive than in asthma, more manifest and consciously accepted and more sexualized '. Similar strained formulation is encountered in the study of Essential Hypertension. It is argued that in hypertension hostile impulses are neither thoroughly repressed nor adequately expressed, and thus a psychological tension results which serves as a constant vasomotor stimulus. ' The crucial point may be the proximity of the hostilities to motility.'

French contributes instructive and challenging ideas in ' Physiology of Behaviour and Choice of Neurosis '. He tries to correlate, through dream interpretation, the phenomena of displacement of energy, physiological excitation and somatic manifestations.

Alexander, reporting ' A Case of Peptic Ulcer and Personality Disorder ' treated in thirty-six sessions, calls attention to the efficacy of ' therapy conducted in less frequent but more active interviews ', and Alexander and French, in ' Psychotherapy in Bronchial Asthma ', stress that ' relatively uncomplicated cases of psychogenic asthma require little or no treatment other than that which aims to make the patient more and more secure in the confidence that nothing he may need to confess will be disturbing or offensive to the therapist ' (p. 250).

The value of these papers lies in their attempt to find the common denominator in the personality and environment of individuals who succumb to similar ailments. It is a problem which demands a great deal of further research, and Alexander and his colleagues are aware of this, although logically specific factors are to be expected.

Paul Goolker.

Basic Principles of Psychoanalysis. By A. A. Brill. With an introduction by Philip R. Lehrman. (Doubleday & Co., New York. Pp. xv and 298. Price, $3.45.)

Brill's *Basic Principles of Psychoanalysis* first appeared in 1921. This book, couched in simple terms and taken from material used in lectures to psychologists and educators, represents another of Dr. Brill's indefatigable efforts to arouse interest and spread information about psycho-analysis in ever widening circles. In conception and approach, the work shows the strong influence of Freud's *General Introduction to Psychoanalysis* which had appeared a short time previously. Chapters on the cathartic method, the symptom, psychopathology of everyday life, wit and dreams comprise the great body of the book and succeed admirably in conveying clearly to lay readers the fundamental ideas of Freud. Cases cited from the vast personal experience of Dr. Brill illustrate, in the earthy and witty way which he made familiar to two generations of students, the meaning and application of psycho-analytic doctrines. In chapters on ' The Only Child ' and on ' Fairy Tales and Artistic Productions,' the author finds the opportunity to record his own personal observations and opinions with regard to the upbringing of children. Finally, in a discussion on ' The Selection of Vocations ', there are valuable comments on unconscious factors involved in the choice of a career.

It lends a touching and symbolic note to this work to learn that on the occasion of his departure for the hospital during his last illness, Dr. Brill took the manuscript of the book with him in order to make the final corrections. When it became apparent that the task lay beyond his strength, he requested that it be carried on by his colleague, Dr. Lehrman, who fulfilled this wish and furnished the book with an introduction.

Mark Kanzer.